

ISPS_{AND}
IIS SyMPOSIA

FIFTY YEARS OF HUMANISTIC TREATMENT OF PSYCHOSES

In Honour of the History of the International Society for the Psychological
Treatments of the Schizophrenias and Other Psychoses, 1956 - 2006.

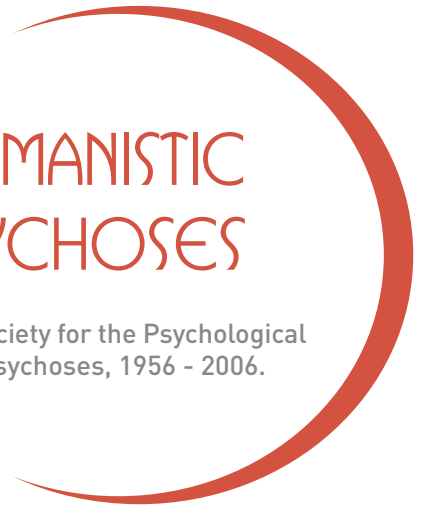
Yrjö O. Alanen
Ann-Louise S. Silver
Manuel González de Chávez
Editors



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Selection and Editorial matter, Yrjö Alanen, Ann Louise S.Silver and Manuel González de Chávez. Individual chapters, the contributors.

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INDEX

List of Contributors	7
1 <i>Introduction</i> Yrjö O. Alanen, Ann-Louise S. Silver, Manuel González de Chávez	11

Part I: HISTORY OF THE ISPS SYMPOSIA

2 <i>Beginnings of the International Symposia for the Psychotherapy of Schizophrenia</i> Christian Müller	23
3 <i>The First Three ISPS Symposia on the Psychotherapy of Schizophrenia in Cery (Lausanne) and Brestenberg (near Zurich), 1956, 1959 and 1964</i> Gaetano Benedetti	31
4 <i>The IVth ISPS Symposium In Turku, Finland in August 4 – 7, 1971</i> Yrjö O Alanen	49
5 <i>The Vth ISPS Symposium In Oslo, Norway, August 13 -17, 1975</i> Jarl Jørstad, Svein Haugsjerd, Bjorn Ostberg	67
6 <i>The VIth ISPS Symposium In Cery/Lausanne, Switzerland, September 28-30, 1978</i> Christian Müller	91
7 <i>The VIIth ISPS Symposium In Heidelberg, Germany in 30.9-2.10 1981</i> Helm Stierlin	97
8 <i>The VIIIth ISPS Symposium In New Haven, Conn., U.S.A, in October 1984</i> Ann-Louise S. Silver and Stanley Possick	109
9 <i>The IXth ISPS Symposium in Turin. Italy, in August 1988</i> Pier Maria Furlan	123
10 <i>The Xth ISPS Symposium In Stockholm, Sweden, in August 11-15 1991</i> Johan Cullberg	145

11	<i>The XIth ISPS Symposium June 12.-16.1994 in Washington, DC, U.S.A.</i> Stanley Possick and Ann-Louise S. Silver	157
12	<i>The XIIth ISPS Symposium in London, October 1997</i> Brian V. Martindale	167
13	<i>The XIIIth ISPS Symposium in Stavanger, Norway, on June 2000</i> Jan Olav Johannessen and Gerd Ragna Bloch Thorsen	189
14	<i>The XIVth ISPS Symposium in Melbourne, Australia, in September 22.-24, 2003</i> Patrick Mc Gorry	205
15	<i>Planning of the ISPS Congress (Symposium XV) in Madrid 2006</i> Manuel González de Chávez	219

Part II: THE ISPS TODAY

	The ISPS gets organized	231
16	<i>The Establishment of the International Society for the Psychological Treatments of Schizophrenia and Other Psychoses</i> Brian Martindale and Jan Olav Johannessen	233
17	<i>Development of the ISPS newsletter, website and secretariat</i> Torleif Ruud	241
18	<i>ISPS in the Age of the Internet</i> Chris Burford	247
	Establishment of Local ISPS activities	259
19	<i>Europe</i> Brian Martindale and Jan-Olav Johannessen	261
20.A	<i>United States of America</i> Ann-Louise S. Silver	273
20.B	<i>Australia</i> John Gleeson	291
20.C	<i>New Zealand</i> John Read, Jim Burdett, Jim Geekie, Helen P. Hamer, Patte Randal, Dale Rook, Melissa Taitimu	295
20.D	<i>Eastern Asia: The Singapore Chapter</i> Lyn Chua	297

Breaking the Covenant	301
21.A <i>International schizophrenia research and the concept of patient-centredness 1988 – 2004</i> Timothy Calton, Anna Cheetham, Karen D’Silva & Christine Glazebrook	303
21.B <i>Commentary on “Breaking the Covenant: International Schizophrenia Research and the Concept of Patient-Centredness 1988-2004” by Timothy Calton, Anna Cheetham, Karen D’Silva and Christine Glazebrook.</i> Brian Koehler	321

Part III: VIEWS ON THE FUTURE DEVELOPMENT OF THE ISPS

22 <i>My Views for the Future Development of the ISPS</i> Gaetano Benedetti	327
23 <i>The Understanding and Treatment of People with Schizophrenia</i> John S. Strauss	331
24 <i>Towards a deeper integration of psychological and humanistic values in the psychiatry of psychoses</i> Johan Cullberg	339
25 <i>The Future of Psycho-Social Approaches to Schizophrenia: Facing up to the Challenges Ahead</i> John Read	343

PART IV: ANNEXES

I.- The ISPS Constitution	355
II.- History of ISPS Board members 1990-2006	363
III.- ISPS Life Honorary Members.	365
Yrjö O. Alanen, Finland (1994-) by Manuel González de Chávez	367
Gaetano Benedetti, Switzerland (1994-) by Brian Koehler	371
L. Bryce Boyer, U.S.A. (1994- 2000) by Sue von Baeyerer	375

Johan Cullberg, Sweden (2003-) by Sonja Levander	379
Stephen Fleck, U.S.A. (1994-2003) by Ann-Louise S. Silver	383
Murray Jackson, U.K. (1994-) by Brian Martindale	387
Jarl Jørstad, Norway (1994-) by Svein Haugsjerd	389
Julian Leff, U.K. (2003-) by Brian Martindale	393
Theodore Lidz, U.S.A. (1994-2001) by Ann-Louise S. Silver	397
Christian Müller, Switzerland (1994-) by Luc Ciompi	401
Barbro Sandin, Sweden (1997-) by Kia Sjöström	403
Harold F. Searles, U.S.A. (2003-) by Ann-Louise S. Silver	407
Helm Stierlin, Germany (1997-) by Michael Wirsching	411
John S. Strauss, U.S.A. (2003-) by Ann-Louise S. Silver	413
Endre Ugelstad, Norway (1994-1996) by Torleif Ruud	417
Lyman C. Wynne, U.S.A. (1994-) by Susan McDaniel	421

CONCLUDING WORDS

Manuel González de Chávez, Ann-Louise S. Silver, Yrjö O. Alanen	423
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NEXT BOOK!	433
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CHAPT. 1 PHOTOGRAPHS



Yrjö O. Alanen

CHAPT. 1 PHOTOGRAPHS



Ann Silver



Dr. Manuel González de Chávez

1. Introduction

Yrjö O. Alanen, Ann-Louise S. Silver, Manuel González de Chávez

The XVth ISPS congress in Madrid is taking place 50 years after the first International Symposium for the Psychotherapy of Schizophrenia was held in Lausanne, Switzerland, in 1956. This stimulated the chairman of the Madrid organisational committee, Professor Manuel González de Chávez, to effectuate a history of the ISPS (now The International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses). He asked two colleagues who were actively participating in the ISPS activities to be his co-workers, one from the U.S.A. (Dr. Silver), and the other from the Northern Europe (Prof. Alanen), both areas known for their impressive role in the development of psychotherapy of psychoses and the ISPS activities.

We shall first go to Central Europe, the actual birthplace of ISPS. At that time, in the mid-1950s, two young Swiss psychiatrists, Christian Müller and the Italian-born Gaetano Benedetti – both around thirty-five years old – dissatisfied with the predominant ways of treating schizophrenia, decided to gather together colleagues they knew through their interest and writings dealing with psychoanalytically oriented treatment of schizophrenic patients. We are very lucky to still have both of these “founding fathers” among us, in good mental strength and able to describe for us vividly their memories of the establishment as well as contents and discussions of the first ISPS symposia, held in Switzerland in 1956, 1959 and 1964. The number of participants in these first symposia was restricted (about 30 in each), most of them coming from Switzerland, Germany and France. In accordance with this, the great majority of the presentations were given in German or French. It is very encouraging for us to read Benedetti’s and Müller’s descriptions, including their continued faithfulness to their original ideas, emphasizing the significance of the personal commitment of the therapist to his/her patient, based on efforts to understand the origins of their problems – something which both of them strongly express at the end of their contributions.

This book has been divided into two sections, the first one describing all the ISPS symposia arranged until now. The second one, entitled “The ISPS today,” deals with the establishment of the ISPS as a society in the 1990s and with the local ISPS activities. To complete this section, we asked some

persons actively engaged in the ISPS activities, among them Professor Benedetti, to present their views on the future of our association.

The fourth and fifth symposia were arranged in the Scandinavian area, in 1971 in Turku, Finland (chair: Yrjö Alanen) and in 1975 in Oslo, Norway (Jarl Jorstad and Endre Ugelstad). The development of schizophrenia psychotherapy had come to have new dimensions, still predominantly based on psychodynamic understanding. This was very visible in the planning of the programme in Turku: besides individual psychotherapy and on equal basis, family therapy and therapeutic communities were included. Another change was the invitation of several U.S. and British psychotherapists to contribute with their presentations. The same orientation continued in the Oslo symposium, and a welcome innovation there was the disappearance of the restriction regarding the number of participants. In the Swiss symposia the organizers wanted an intimate discussion atmosphere between the therapists; however, the new regime also allowed younger and less experienced therapists the possibility to participate. This had a great positive impetus for their future work.

The language used was now English, very reasonable from the point of view of the symposia's larger yield and scope. A disadvantage was the diminished interest of therapists from Central Europe in the ISPS activities. Despite the fact that the next two very successful symposia were organised again in Lausanne in 1978 (Christian Müller), and in 1981 in Heidelberg, Germany (Helm Stierlin, Lyman C. Wynne and Michael Wirsching), this feature was not permanently corrected, especially with regard to participants from France.

In Heidelberg different orientations of family research and therapy formed the largest bulk of presentations, seconded by treatment settings and individual psychotherapy. It was followed by the first symposium arranged in the U.S.A. in 1984 in New Haven, Conn., likewise chaired by distinguished pioneers of family studies on schizophrenia, Theodore Lidz and Stephen Fleck. In his keynote address Lidz strongly deplored the neglect of psychosocial therapies that were already visible in the development of American psychiatry. The psychoanalytic tradition in the treatment of psychoses pioneered in the United States was still strongly present in this symposium.

The next symposium was held in Turin, Italy, in 1988, organised by Pier Maria Furlan, in cooperation with Benedetti. It became the largest one ISPS has held to date, with 1300 participants. Four hundred of them came from Italy and simultaneous interpretation of the presentations was arranged. The

symposium was the first one to have a subtitle defining the main goals of the organizers: "Approaches to Psychosis: from the One-to-One Laboratory to the Psychosocial Models." The presentations gave a very vivid and many-sided picture of the great interest in different psychotherapeutic activities prevalent at the end of the 1980s, with emphasis on both psychodynamic and larger psychosocial approaches.

In the symposia arranged during the 1990s, a gradual change from psychodynamic approaches to a greater plurality was noticeable, even arousing some controversies inside the ISPS membership circle. This also included strivings - with varying success - for integrative contacts with approaches based on other kinds of starting-points. The amount of participants of symposia arranged in Europe remained rather high, between 700 and 1000 both in Stockholm, Sweden, 1991 (Johan Cullberg), London, U.K., 1997 (Brian Martindale) and Stavanger, Norway, 2000 (Jan Olav Johannessen). In Washington, D.C., U.S.A., 1994 (David Feinsilver) and Melbourne, Australia, 2003 (Patrick McGorry) it was somewhat lower. The tradition to give the symposium a subtitle was continued and especially those of the Washington and London symposia were revealing: "Psychotherapy and Comprehensive Treatment" (Washington), and "Building Bridges" (London).

In the Stockholm symposium one of the features enlarged on was the attention to the cognitive-behavioural and educational methods besides those with psychodynamic basis. This development was continued especially in London and Melbourne, and new studies emphasizing the importance of early treatment and preventive activities also came to the foreground. Some biologically oriented researchers were invited to participate in the program in Washington, D.C., as well as in Stavanger symposia. However, we experienced that the endeavour to find integrative viewpoints with each other seemed - despite our own controversies - to be greater among the psychotherapists than among biologically oriented researchers and clinicians. A more integrated development between psychological and biological standpoints in the study and understanding of schizophrenic psychoses apparently had to wait for its time.

In several later ISPS symposia, representatives of the consumer associations - people living with psychotic illness, as well as those of their relatives - have been among the invited participants. In the Melbourne symposium, one of the highlights was the plenary speech by Dr. Fred Frese. He represented the National Alliance for the Mentally Ill in the U.S.A., and had, himself, recovered

from schizophrenia. He is now the Director of Psychology in the clinical service in which he once was a patient.

For a long time, the international symposia were the only function of the ISPS. An informal executive committee was formed in the 1970s, its members mostly coming from the chairmen of former symposia. The most important function of this organ was to decide on the place of the next symposium, made in a meeting during the preceding one. The organisation of the symposia was, in practice, left to the local group, formed and led by a dedicated chairperson joining the international executive committee.

Even if the symposia in this form had a very important stimulating effect, the need for more regular and extended activities gradually became obvious. The idea to develop a broader range of ISPS activities besides the symposia was expressed by many long-time ISPS pioneers, especially by the perhaps most dedicated among the members of the informal executive committee, Endre Ugelstad from Norway, whose untimely death soon afflicted us with grief.

Parallel with the extending plurality of the approaches, these thoughts further strengthened, and the need to develop the activities of the ISPS in a more organised setting became of current interest. In the Washington symposium in 1994 the idea of developing the ISPS into a society was already being discussed. The informal executive committee increased its meetings, beginning to plan the constitution for the society to be established. A draft for this purpose was prepared by Brian Martindale before the London symposium and accepted there under his leadership. The established community was named *The International Society for the Psychological Treatments of Schizophrenia and other Psychoses*, thus emphasising the broadening scope of the objectives and activities of the new society. A formal executive committee was elected in a meeting open to all the symposium participants. However, the letters ISPS were maintained as the emblem and a shortened sign of the society, thus retaining the continuity and reminding us of the roots of the society.

The most important part of the broadened functions soon became the establishment of local ISPS branches in individual countries in different parts of the world. As described in our book, the development of local activities has varied greatly until now, being very active in some of the countries and hardly begun in many others.

Looking at the present situation, the more comprehensive psychotherapeutic approach, also including orientations outside of the original psychodynamic starting-points, has been generally adopted by the ISPS. Together with the development of more integrated therapeutic approaches, this seems very reasonable. However, the study by Calton et al. on the distribution of the ISPS symposium abstracts from 1988 to 2003 to categories representing different psychotherapeutic orientations, included in our book, is apt to give rise to concern: are we going too far away from our original goals and convictions? We should not forget the starting point of all genuine psychotherapeutic work with schizophrenic and other psychotic patients – whether it is based on psychoanalytic/dynamic or cognitive/educational approaches, or whether its object is the individual patient or the interactional network around him: It should be based on an empathic and understanding approach to the problems of the people we are treating, and on endeavours to help their growth as human beings and to increase their interpersonal and social capabilities.

The need to promote psychological and humanistic approaches, as opposed to the still dominant way to restrict the treatment of psychoses one-sidedly to drugs, was strongly expressed, in different forms, by the ISPS members whose views for the future of the ISPS were asked for in our book: these being one of our two “founding fathers,” Gaetano Benedetti, two dedicated representatives of the older ISPS generation, John S. Strauss and Johan Cullberg (all of them Life Honorary Members of the ISPS), and one very active representative of the younger ISPS generation, John Read. Another common emphasis in their lucid texts was the hope to develop the ISPS into an even more important and influential global centre for the study of psychotherapeutic treatment approaches to schizophrenia and other psychoses than what it is now, both in theory and practise.

We hope that these views can guide us to work in the further strengthening of the ISPS and its activities during the coming decades.

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PART I:

HISTORY OF THE ISPS SYMPOSIA

*Gaetano Benedetti and
Christian Müller, during III
Symposium*



*Auditorium First Symposium
Laussane 1956*

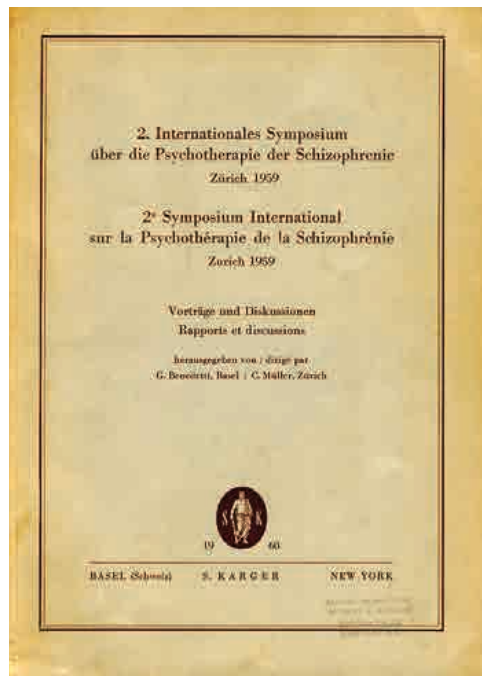
CHAPT. 2 and 3 PHOTOGRAPHS



*Margarite Secheyay
Symposium 1956*



*Christian Muller
(on the left) and
Gustav Bally
Symposium I*



Book of II Symposium

CHAPT. 2 and 3 PHOTOGRAPHS



*Symposium 1956
Ludwig Binswanger speaking*



*Gaetano Benedetti
Symposium 1956*

2. Beginnings of the International Symposia for the Psychotherapy of Schizophrenia

Christian Müller

[Originally in German. English translation by Philip Isenberg. This paper, as well the next one by Benedetti, are reproduced, with the revisions made by the authors, from Gaetano Benedetti und Christian Müller: Psychotherapie der Psychosen. Schriften der Blum-Zulliger-Stiftung Bern zur Geschichte der Psychoanalyse, Nr 1, edited by K. Weber, 2001.]

The first of these Symposia took place in 1956 in Cery/Lausanne. When I recalled that time and read the lectures of that colloquium, I was once again immersed in the very special and enthusiastic atmosphere of that period, including the years between 1945 and 1950, in which we participants concluded our basic psychiatric education. What were our theoretical positions, our interests and convictions?

We came from a time in which our predecessors in Switzerland had developed methods of therapy that today would be called "biological" – insulin therapy, electroshock,¹ the sleeping cure. The two Bleulers, father and son, were the undisputed masters of our profession. And I see a particular quality of Switzerland in the fact that it was above all psychiatrists with a psychodynamic concept who were interested in these treatments. I will mention only two: Prof. Jakob Klaesi in Bern and my father, Professor Max Müller. Even today, it seems to me that this connection of the two sides was the expression of an openness toward everything that was interesting and toward anything that might perhaps improve the tragic destiny of schizophrenics who were herded together in the psychiatric hospitals of the era. The existential analysis (Daseinanalyse) of Binswanger and Boss

¹ That is what the "electroconvulsive" therapy was called, the artificial triggering of an epileptic seizure (aside from the initial times under anesthesia) which had an indubitable effect with severe depressions and catatonias. In lay publications, it was described – and continues to be described today – as if it were a sort of torture method, that is, the administering of painful electric shocks.

interested us, even left its mark on us, but for the temperament of us young psychiatrists, all of these theories were too philosophical and too far removed from practice.

And how did things stand with psychoanalysis? It was of course always current in Switzerland, more so than abroad, but it was condemned to a nearly subversive and clandestine existence. I was not the only one of my generation who had to do his training analysis in secret without the knowledge of the chief. But this hiding was for us also a reason for enthusiasm, and in a small way, it also belonged to realm of opposition against fathers.² What was taught back then? A psychopathology that was strongly influenced by Jaspers, the differential diagnosis between organic and functional psychoses. Psychopharmacology was at its beginning. Our daily work was the examination and correct description of the patients, the meticulous recording of clinical histories, the reports, then the injection of the soporifics for the sleeping cures, and the special nutrition of patients who refused to eat.

And the psychotherapy of psychoses? We had a vague idea about the pioneering work at the beginning of the century under the influence of Eugen Bleuler. People such as Alphonse Maeder, Sabine Spielrein, Karl Abraham, Johann Jakob Honegger, and, above all, Carl Gustav Jung attempted, on the basis of Freudian ideas, to see the sense in schizophrenic symptoms, whether they were hallucinations, delusions, autism, or dissociation. We hardly read the writings of these predecessors. They had disappeared from our field of perception, for reasons that are easily recognizable: their attempts to approach the psychoses did not have any ascertainable effect at the practical level. They were intellectual efforts, to understand, to explain, to interpret, without any great significance for the fate of the patients.

At the time of our training in Zurich and Lausanne, however, two authors appeared whose publications immediately fascinated us and filled us with enthusiasm. They were two Swiss women, Gertrud Schwing³ and Marguerite Secheyay,⁴ both of whom had worked in private practice as psychoanalysts

² By this, Christian Müller, who did his training in Zurich, means the “fathers” there and not his natural father with whom he is indeed agreed in this matter.

³ Gertrud Boller-Schwing, 1905-1993.

⁴ Marguerite Secheyay-Burdet, 1887-1964

with schizophrenics, one in Vienna, the other in Geneva. That challenged us to be active with our patients, not to lose heart if our interpretations did not get to them, to dedicate a great deal of time to them. What emerged above all from Ms. Secheyay was the attempt to correct the deficiency from which the patient was suffering through that which she called symbolic realization (*réalisation symbolique*; Secheyay, 1947).

A third bombshell shook up the tranquil sleep of the clinical psychiatrist who was satisfied if his patients were calmed by the sleeping cure or insulin therapy. That was the book by John Rosen (1953) about direct analysis. He promoted an active – I would say virtually overwhelming – penetrating, aggressive attitude, a battle with the patient, an active participation in the drama of the psychosis, an identification of the therapist with that which the patient projected in him, mother image, father image, and so on, and all of that excited us and stimulated us to the highest degree. Of course, we would later experience that the concepts of Ms. Secheyay, like those of John Rosen, were not flawless, and today we would no longer be able to blindly accept them. But during the years 1952-56, in Zurich and Lausanne, we tested these theories with eagerness without any difficulties being able to deter us. In Burghölzli, in Zurich, colleagues were bubbling with enthusiasm in their activity during sessions with one patient, they kept contact with him under horrible conditions, accompanied by screaming, acts of violence, stereotypies, rejection, and so forth with regard to the sometimes half-naked, agitated, swearing, shrieking patient in a cell. To put it briefly, it was a truly heroic atmosphere in which the attempt was made to maintain contact with an autistic patient at any cost. I later attempted to portray the results of these bold and fascinating endeavors in detail in an article (Müller, 1961). They sometimes ended with a spectacular improvement in the condition of the patient.⁵

As a consequence of those experiences, the idea came to me to bring together in discussion all those in Switzerland and abroad who were interested in this new approach. My friend Benedetti, whom Manfred Bleuler had sent to the USA for training with Rosen, was at once completely

⁵ The editors would like to note that one of the most imposing case histories was published by the writer himself (Müller, 1955).

keen on the undertaking, and together we began to organize these Symposia. That was in 1955-56. Benedetti was working at the time in Basel, and I was a senior physician under Steck in Lausanne. With regard to the situation from which we started out, Benedetti wrote in 1991, "We were dissatisfied with the predominantly organicistic orientation of European psychiatry and had sought the aid of psychoanalysis... First and foremost, it was necessary for us to clear two misunderstandings out of the way. The first of these was that the psychotherapy of schizophrenia was nothing more than an intensification of the habitual contact between doctor and patient, made up of compassion, benevolence and conscious responsibility, and not a commitment which requires from the therapist a serious and complex preparation, both theoretical and practical. The second misunderstanding was that psychotherapy was just one of many methods to which one can recourse when the others have to be unsatisfactory." (Benedetti, 1992).

If today, nearly sixty years later, I take the documents and correspondence in hand, I cannot help but feel a certain pride for my courage and enthusiasm. Organizing an international conference with the participation of colleagues from Germany, France, and England was something new both for myself and for psychiatry in Lausanne. What nerve, for a thirty-four year-old whippersnapper to turn directly to the greats of European psychotherapy and invite them to Lausanne! I organized and wrote invitations to Racamier, de Saussure, Lebovici, Mitscherlich, Binswanger, and others, all the while keeping up my duties as the senior physician who was responsible for half of the hospital, the men's section (at that time, the patients' sections were still divided by sex). It was a great help that Benedetti and I formed a homogeneous duo whereby with time, he dedicated more time to theory while I was more occupied with the organization. In a letter of October 4, 1956, he wrote to me, among other things, "Dear Christian, the entire weight of this symposium rests upon your shoulders while I'm having a fine and relaxing time in Sicily. But I hope to be able to make good again next time, because I greatly hope that this gathering will be the first of an entire series."

Benedetti was right, the Symposia would continue to this very day. The response was very favorable, the publication by Karger was a success, and three years later, in 1959, we met in the German-speaking part of Switzerland, in Brestenberg, and in 1964 again in Cery. Each time, the number of participants increased, and soon the problem no longer consisted

of finding lecturers, but rather having to hurt feelings by rejections. Symposia then followed abroad: in Turku, Finland and in Oslo, Norway, then back to Cery for the third time in 1978.

As at any conference, they included enthusiasm and disappointments, rivalries and jealousy, and numerous memories of particular episodes remain. For instance, when the *grande dame* of Freudian psychoanalysis, Frau Kestenberg, came into conflict with the *grande dame* of family therapy, Frau Selvini, in the lecture hall at Cery. Frau Kestenberg asked Frau Selvini why she always wanted to be right. "Because I am right," was the response.

Another episode occurred in Heidelberg, where my friend *Helm Stierlin* had organized the Symposium. I had been invited to give the introductory lecture in the great historical hall of the university. While I was speaking, someone suddenly stood up, pushed his way through the rows to me, and began to speak in a delusional manner. It was a schizophrenic who had mixed in with the public. Stierlin and I attempted to convince him that he should not interrupt the meeting. That was one very lively and direct encounter with our topic.

On the same occasion in Heidelberg, Stierlin spoke of the twenty-five years that had elapsed since the first Symposium in Cery. He said that the child had grown up and its character had changed, it had learned English and had become more capable of traveling. "I don't know whether this child has developed in accordance with the wishes and expectations of its fathers. Without a doubt, this Symposium has for many become something respectable and attractive." In actuality, the ISPS (The International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses) which today organizes the Symposium for the Psychotherapy of Psychoses, has members throughout the entire world, sections in many countries, and everything that belongs to a modern institution; even the website is not lacking. In the beginning, it was the forty of us; that has now turned into several hundred.

And I, the father, have become the grandfather or even the great-grandfather. We founders have been named as honorary members and have received medals. If someone gets medals, though, does that mean that the act is over, the curtain falls, and one is ready for the daisies?

How do I feel about this development, am I proud of it? Yes or no? Yes, because with the predominance of "biological" psychiatry, it is important

that an international organization actively maintains and defends the psychodynamic point of view. No, because precisely that ideal which Benedetti and I pursued at that time no longer has the same meaning as it did back then. Let us understand each other correctly when we speak of psychodynamic thinking. I do not want to simply refer to the writings and ideas of Freud, but rather to an attitude. I would like to characterize this attitude as follows: it is about not just describing the phenomena of the illness, but rather understanding its sense, its meaning for the patient. In my instruction, I have also always tried to arouse inquisitiveness about what this "loss of the sense of reality" means, what the emergence of "madness" (and I use this old word intentionally) means in the life of the patient, because I am most deeply convinced that only the tireless efforts for understanding also give us the possibility to create lively human contact with the patient. It is not sufficient to organize that which today is called "community-based" sociotherapy so that the patient can be integrated or can remain in a social network. No, that is really not enough for me. Furthermore, I think that what is essential in the process of a therapy with the schizophrenic is the unconditional personal commitment of a therapist who, starting from that which he has understood about his patient, attempts to deal with him in a different manner than what he has experienced up to that point. It can be called "correcting experience," which seemed to me to be a very essential thing during the entire period of my work. This type of personal commitment, that is my "credo," the flag that I will hold up as long as my strength allows.

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3. The First Three ISPS Symposia on the Psychotherapy of Schizophrenia in Cery (Lausanne) and Brestenberg (near Zurich), 1956, 1959 and 1964

Gaetano Benedetti

(Original in German. English translation Philip Isenberg)

The history of the International Symposium on the Psychotherapy of Schizophrenia began during the early 1950s. An important impetus was the collaboration with my friend and colleague, *Christian Müller*, in Burghölzli, the internationally renowned university psychiatric clinic in Zurich. Encouraged by the benevolent support of *Manfred Bleuler*, then medical director of the clinic, we undertook the first psychotherapeutic attempts in this difficult field which, at that time, was so controversial.

What was opening up there was a fruitful and encouraging time of collaboration all the more so considering that the pharmacological therapy was still very much at its beginning and the pioneers of a psychotherapeutic approach to schizophrenia could with complete justification refer to a purely biologically oriented psychiatry as being impotent.

At that time, we established a dialogue with young, open, non-dogmatic psychiatrists from different countries who were capable of demonstrating enthusiasm. We wanted to exchange our experiences and to mutually provide each other with stimuli and inspiration.

In the wake of the relocation to Lausanne of Christian Müller, who became an important representative of our matter of concern in French Switzerland, it seemed to us that the time had come for a first symposium. The results were reflected in the number of interested participants and in the high quality of the discussions, and thus the groundwork was laid for two

additional symposia in subsequent years which took place in Brestenberg, Switzerland and then again in Lausanne.

In the attempt to bring alive old memories of the collaboration with you, I looked through the journals of the first three symposia which Müller and I edited between 1956 and 1964. They reflect that time back when our Symposium was always held in Switzerland, either at Cery (in Lausanne) or in Brestenberg (near Zurich) and was based upon relationships that were still personal or would soon become so.

A photo album which I kept at that time helped me to recall the faces of friends and acquaintances. In the intervening period, many of them have passed away or, like Christian and I, have gotten older.

If I were now to attempt first of all to indicate what it was that first and foremost radiated from those Symposia, then I would begin with two impressions: firstly, what struck me upon rereading was the enthusiasm that Christian knew how to arouse in all of us, an enthusiasm that resulted not just from the main speakers, but also from the discussions that were also printed. This enthusiasm, which never ceased to be critical, nevertheless had a quality that was youthful, fresh, and persuasive – as if it were possessed by people who understood themselves to be innovators – yet also seized the older participants.

Let us turn, for example, to the words of the venerated *Ludwig Binswanger* (Photo) with which he inaugurated the discussion at the 2nd Symposium:

For me, the penetration of the psychotherapy of schizophrenia into psychiatry signified the second great event in my more than fifty years of collaboration on the history of psychiatry. The first, of which the current situation vividly reminds me, was the onset of Freud's psychoanalysis. (L. Binswanger, 2nd Symposium, p. 25.)

As early as the First Symposium, a remark from *Helmut Bach* of Berlin placed similar emphasis:

If I now extend my comparison to the measures for treatment, then I may well begin with the idea that today, Freud would probably have long ago departed from his thesis of the therapeutic inaccessibility of narcissistic illnesses.

The hope of having found in the psychotherapy of schizophrenia a key to the healing was so great that there was no lack of voices that wanted to avoid a pharmacologically induced remission of the psychosis before the psychological healing. In that regard, I turn to the words of one of the great psychotherapists, *Adelheid Fuchs-Kamp*, whom I visited many years later along with my wife in a Berlin old age home and who then, even in the last years of her life, radiated such a human aura that her neighbor at the table, as she told me, always wanted to eat a bite from her plate. Here is her remark (Fuchs-Kamp, Volume 2, p. 157):

With regard to this therapeutic goal, I had to direct my efforts from the very beginning at avoiding a remission under all circumstances, which in this case to which I essentially wish to refer would not have been easy to achieve. The remission loomed as a possibility even worryingly soon during the first days of the stay in the clinic. The fact that such an objective poses particular challenges is something that you will be able to appreciate since in psychiatric clinics in general, a remission is looked upon as an optimal result, to be viewed virtually as a cure of a psychotic episode. A true cure, for which I strove for A., was only to be hoped for if I were to be successful under all circumstances in keeping up the drive to live that had first chaotically broken down in the psychosis, in order to be able to use it fruitfully with the patient.

But in this regard, the wise voice of *Walter Bräutigam* (3rd Symposium, pp. 185-86) certainly makes a more critical emphasis:

The question appears to be whether one can still accept the responsibility today of not actively and somatically treating an acute psychotic. For the patient, the period in the psychosis is in any case a time of great fear, unproductive strain, and a time with thoroughly humiliating experiences for his self-consciousness.

The second prominent feature of the Symposia was the disclosure of a new image of the schizophrenic person, the disclosure of a deeper relationship to the patient which – although it was indeed prepared by Bleulerian psychiatry which emphasized that which is human and by *Daseinanalyse* (existential analysis, which was the first to speak of a “world” of the schizophrenic person) – was also understood in this context in psychoanalytical terms. Freud and Jung, Bleuler and Binswanger, all of them, each on his own level of thought, viewed schizophrenia in psychological terms; none of them,

however, had placed the relationship to the patient in the focus of attention to such a degree and made such demands as was now occurring. Whether it was “symbolic realization” or “relatedness” that was spoken of, whether “basic trust” or the “constancy and reliability of the relationship”, a new wind was blowing everywhere.

At this point, I will let some of the advocates of this “great change” speak:

(*Silvano Arieti*, 2nd Symposium, p. 9) [English in original]:

I could say that it is a communication with “the naked and native dignity of man.” The patient must acquire a feeling of reliance and trust. In normal development the mother-child relation engenders what has been called basic trust: a complex, interpersonal feeling which consists of the expectation, on the part of the child, that the mother will be there to give and love; and of the taken for granted idea, on the part of the mother, that the child will grow up to be a normal and worthy and loving person.

In the therapeutic situation the patient must experience something reminiscent of this basic trust, as perhaps he never experienced. This trust must be conferred by the simplicity, strength and forwardness of the therapist, not by his solicitous benevolence. In some cases the patient needs to lean and cling, to be talked to for hours and hours. The therapist has the feeling he has to perform almost a psychological blood transfusion. The needs of the patient may be so great, as to be indeed impossible to satisfy if we adhere to our schedule or to the conventional ways of private practice.

And already at the first Symposium, *Marguerite Sechehaye* stated [French in original]:

*I have always regretted having entitled my book *Réalisation symbolique* [Sechehaye 1947, engl. *Symbolic Realization*, 1951], because the apples that I gave to Renée were not a symbol of mother’s milk but rather the mother’s milk itself. It was not a symbol, but rather a “magical, pre-symbolic participation.”*

P. C. Racamier, however, presents a slightly differentiated opinion [1st Symposium, p. 130] [French in original]:

I also think that in the relationship with the schizophrenic, the dialectic of the gift and of the frustration is a fundamental given. Genetic studies show us that the child succeeds in grabbing hold of the object – that is, reality – and the make-up of his person only through an alternating series of gratifications and frustrations that are literally founders of reality. Systematically frustrating the schizophrenic or systematically gratifying and satisfying him are two perfect ways of pushing him into his alienation.

The slightly differentiated opinion of *Gustav Bally* also places a similar emphasis (Bally, 2nd Symposium, p. 219) (Photo):

In that regard, too little consideration is paid to the fact that the patient is not just, nor even first and foremost, a little child or an infant, but rather at the same time an adult who throughout his life had constantly been confronted with situations with which he could not cope. For that reason, the sole granting of infantile satisfactions seems to me to be unbalanced. If it is not supplemented, it provides the patient with too little support. Without a doubt, included in this support is reliable care that corresponds to the care that may be expected from a devoted mother. But, as Stierlin correctly emphasizes, “non-yielding solidarity” includes not just the willingness to soothe the patient, but also a certain restraint. For the schizophrenic patient, the analyst must present a pattern of behavior; that is, with his behavior show real possibilities of association. He can only do this by means of a steady, steadfast constancy.

Indeed, here the clear boundaries are shown between, on one hand, therapists who placed the fulfillment of impulses in the forefront with regressed schizophrenics and, on the other hand, those who also considered the grown-up person of the patient and did not idealize the countertransference.

The first group includes *Marguerite Sechehaye* whom, as a result of her prominent role in all of the Symposia, I quote once again (Sechehaye, 1st Symposium, p. 293) [French in original]:

The more regressive the schizophrenic, the greater the importance of these paraverbal factors. By means of these, the therapist achieves his first objective, which is to move the patient from the autistic state he is in to a symbiotic state with his analyst. Or, as Biswanger would say, “moving the patient out of the world of solitude and abandonment into the dual

world of love and warmth." To do so, it is essential that the schizophrenic perceives, right from the outset, that his psychotherapist is coming to him with the boundless devotion and love of a mother for her ailing child.

But S. Lebovici should also be mentioned at this juncture (Lebovici, 2nd Symposium, p. 66) [French in original]:

When countertransference is underpinned by a profoundly positive attitude, when the psychotherapist's insight enables the introduction of valid psychodramatic counter-attitudes, it seems to us that the psychotherapy is moving in the most favorable direction for these patients. It is gratifying, without catering to the patients' masochistic demands. Such therapy is simultaneously direct, gratifying, and fulfilling. We believe it must be studied as an original tool.

The giving manner is formulated with "love", with loving care (F. W. Beese, 3rd Symposium, p. 132):

We would like to assume, although as a totally preliminary impression, that what is actually effective in individual psychotherapy is the completely general loving care for the patient; however, we can only make this understandable and accessible to him by our understanding his language by our including ourselves under the circumstances in his psychosis.

But what is therapeutic love? In that regard, let us listen to the words of Martti Siirala (Siirala , 1st Symposium, page 309):

With regard to the problem of love in therapy, I wonder whether this term has not again and again been hypostatized by different ideals that we have and whether love is not actually something that does not flow from us to the patients but rather consists of the fact that we remain loyal and steady in the situation with the patient. All of our ideas about love fall apart again and again and we experience something completely different than we expect, and we discover that in the occurrences between the patient and ourselves, hatred and bitterness horn their way in over and over again.

And furthermore from Fritz Meerwein (Meerwein, 1st Symposium, p. 153):

Precisely by the therapist not demanding any healing from the patient, he provides him, without speaking of it, with the trust that the possibilities for

healing lie within him, the patient, himself, and thus only then will he take him seriously.

An essential aspect of the general tendency consists of the fact that the illness is not so much divided according to nosological criteria, as classical psychopathology has done, but rather much more considers the affect of the patient and his transformation into this affect.

Thus, even a colleague who is competent for schizophrenic defective states, such as *Raoul Schindler*, can say (Schindler, 2nd Symposium, p. 281):

If your experiences up until now agree with mine, if the defect represents an image of transformation of the total personality that can only be specified with difficulty, and if variations occur not only in a downward direction but also, so to speak, upward, then, ladies and gentlemen, we actually no longer have any justification in adhering to the term "defect", even if only through our silence. We can only understand it historically as an unfortunate attempt to reduce the schizophrenic illness to the conceptual range of a psychology of elementary functions.

The significance of the affectivity of the patient, which makes communication possible, was emphasized in nearly all of the lectures and discussions precisely as a contrast to the old teaching of the inability to empathize. Thus, we hear from *Marta Eicke* (Eicke, 3rd Symposium, p. 80):

Whatever leads a patient to accusation, dramatic delusions, silence, or verbal incomprehensibility, I attempt to elicit from these statements the affect content, I attempt to test the statement for its communicative quality... I thus offer him what I have experienced from patients without a particular statement on my part. The patient thus no longer then introjects something foreign or a reaction of his partner which would lead him to further depersonalizations, but rather he only still introjects that which he himself already is and which thus for a moment becomes identical with himself. By virtue of the fact that I do not ascribe any interpretations beyond the content of that which has been verbalized, I also draw from the doctor-patient dialog the dangerous possibility that unconscious emotions on my part that influence such interpretations could then be introjected by the patient.

All of this was not just a plain theorizing way of thinking. In a series of impressive case histories, for instance from Winkler, Fuchskamp, Bister, Herner, Neumann, and others, the healing significance of the intense relationship to individual patients is presented in a documentary fashion.

Of course, a fertile polarity appears between the rather philosophically thinking psychiatrists who, like Siirala or Storch, regarded schizophrenic illness within the framework of a split in existence or who used this illness as an opportunity for a view of the societal psychopathology, and other, more clinically oriented colleagues who, like Bräutigam or Schindler, brought out the specific disease character of the illness.

Siirala, for instance, said:

The splits therefore appear to pervade our entire coexistence, indeed, the communal body. They are the same splits that we find in our schizophrenically afflicted fellow men and yet they affect us differently. They are, as it were, more difficult to combat, because even in our task of healing, no agreement prevails with regard to the existence of such a collective illness – and otherwise, very, very few people seem to have any idea about it.

Or the same author once again (Siirala, 2nd Symposium, p. 217):

For me, schizophrenic psychosis – to put it briefly – is a “challenge” to a new reception – after an unsuccessful attempt at an existential solution. It shatters the order of the state of existence that was in effect thus far for those who could not accept any more room for development in that state. Existence sounds itself out anew. That which was threatened by petrification calls for a battle. What, then, is crucial in that situation? Protective boundaries must oppose the chaotic, autism must be met with warmth and spontaneity, the defenses must be met with understanding, respect, and the careful reconciliation of absolute opposites. That which is hidden and that which is offensive require tolerance, gentleness, and above all a vigilant sense of the search for contact that is manifest therein. Regressive behavior leads to the warmth of the nest and the instinctive feel for a genuine childhood that is suitable for the adult.

Or from *Wilhelm Küttemeyer* (Küttemeyer, Volume 2, p. 87):

The view has, however, irrefutably been of an illness of society that is not just called this way metaphorically but is real, if the usual relationship of

the mentally ill person and the doctor, of the patient and those around him at all becomes reversed: from behind the failure of the schizophrenic, an intellectual capacity and sensitivity emerges, greater than that which is "normal", and out of the mental immaturity of the patient, a cosmopolitan attitude surfaces – with respect to a deeper and higher world than that of the usual reality – in which the patient becomes the master of coping with existence for the "healthy." In that context, we must judge whether it is really our movement and our action, whether it is our receptiveness which makes this gradation of the depth of the phenomena visible for us which gives rise to this development and change for us.

Schindler, however, expresses a different opinion (Schindler, Volume 3, p.133):

"Schizophrenia, then, is alas not a strange way of life, however, but rather an illness, that is, an onset that can be described of changing occurrences in a personality that up to that point had been experienced as integrated. It is also not a neurosis which, through elaborate circumventions or supplements of the ego, grants to the fulfillment of desires an illusory satisfaction that is continuous in meaning, but rather a change in the totality and structure of the ego itself, as the relatives correspondingly attest with their observation of a personality change that has occurred and which even expresses the Bleulerian term of schizophrenia, as Stierlin, for his part, has impressed upon us.

The fact, though, that the schizophrenic, in the language of his disease, expresses our own even existential conflicts and symbolically speaks our language was recognized, for example, by A. Storch (Storch, Volume 1, p.231):

There are final human questions which, even where the patient does not actually ask them, are nevertheless expressed in the symptoms of his illness: questions about human existence in this world, about life, death, and the hereafter; about the proto-opposites of good and evil, of God and the devil. They are the fundamental questions of all religions, philosophies, and poetry which in the end are certainly unanswerable. It is also not about theoretical answers, but rather about showing the patient who is disarranged or deranged from our world paths that make possible for him the acceptance of the world and of his own being. Everything depends upon answering genuinely and truthfully to the patient who, in

distress, poses such questions. Only then do we fulfill the task that has been assigned to us as psychotherapists.

An important modification of the psychoanalytical technique in the treatment of schizophrenic patients emerged in numerous lectures and discussions in the 1950s. While many authors – it seems to me to be a minority – still worked closely with interpretations, others recognized that the symbolic game, the psychodrama, the gesture, the so-called “latent therapeutic response” (Hull) played a role in the therapy that was not inconsequential, if not often downright decisive.

It was above all *Herbert A. Rosenfeld*, representing in this context the entire Melanie Klein school, who worked with interpretations similarly to my former teacher, John Rosen. At the 3rd Symposium, he stated (Rosenfeld, Volume 2, p. 202):

Through the interpretation of the negative transference and the ideal transference, the relationship to the analyst becomes more real, that is, less psychotic. With this, I do not mean that the psychotic transference stops absolutely, but rather that a connection is formed between patient and analyst where outside of the psychotic transference, a non-psychotic one exists. This non-psychotic “line of understanding” between the analyst and schizophrenic patients is sometimes narrow and uncertain. But it is important to recognize this opportunity of understanding between the patient and the analyst and to make use of it. This is especially important for the analysis of acute schizophrenias.

Christian Müller replied (Müller, Volume 2, p. 218):

Dr. Rosenfeld has again and again drawn attention to the great importance of interpreting and, in so doing, used the term “interpreting” in evident connection with the spoken word. I nevertheless wonder whether the term “interpretation” ought not to undergo a broadening within the framework of the psychotherapy of schizophrenics, namely, in the sense that it no longer be restricted to verbal communication. We have heard from Lebovici how important the gesture is for clarification, for symbolization, and how often an essential fact becomes accessible to the schizophrenic only in the carrying out of a miming motion. I consequently believe that an exquisitely interpretive function can be inherent even in the gesture. It has indeed already been very correctly stated that it is often difficult to decide whether the schizophrenic

understands and hears the same thing in the word that we pronounce as we have in mind. And the gesture is of course subject to the danger of a false interpretation by the patient. But practical experience shows that it is possible to express that which is specific somewhat more by acting, which is not to be immediately equated with acting in the psychoanalytical sense or with symbolic wish fulfillment.

Racamier likewise expressed his opinion (Racamier, Volume 1, p. 145) [French in original]:

Every analyst since Freud has wanted his or her patients to express, rather than suffer from, their conflicts and their torments in ordinary analysis. The ritual of the therapy promotes verbal expression and prohibits action. With a schizophrenic, this ritual is impossible and would be harmful, and the prohibition of action, if it is to be obeyed, must be more active and stricter. With the schizophrenic, it is not enough to interpret; it is necessary to act, but obviously to act in a comprehensive manner.

At this point, I will cease with the reminiscences and quotes. The three Symposium volumes, edited by Christian Müller and myself, with their articles have transported us to a time in the past that was filled with fascinating new beginnings, and I must repeat how much this early collaboration shaped my thinking. But how could I better bring my remarks to a close than with a leap into the present where, more than forty years later, I described the psychotherapeutic position in the matter of schizophrenia upon receiving the Margrit Egner Award in Zurich in 1999?

My words show how much of those earlier beginnings has remained in my life's work.

This is now both the *old and the young Benedetti* who is speaking to you. In the attempt to represent the valid therapeutic position in the psychotherapy of psychoses thus far, I would like to briefly formulate three dimensions:

1. The manner of understanding
2. The affective closeness
3. The positive distance

These three keywords shall be further explained below.

1. The manner of understanding is multilayered. It corresponds first of all to the therapeutic *need* to understand every behavior of the patient in its hidden motivation and to check the causal chain of its conditions. It requires *patience* in view of the motivation of the patient that is deeply unconscious and only decipherable in several attempts at understanding. It also requires *curiosity* in the inexhaustible exploration of the unconscious, as well as the *courage* to venture one's own psychodynamic hypotheses in order to clearly see a completely sensible clinical picture.

Creative therapeutic ideas and projections of one's own symbols do not distort the objective form of the illness because they increase this intersubjectively and the dual dimension of existence even opens up in the psychopathology. The manner of understanding means the readiness of the therapist to introject defended and separated feelings of the patient in order to consciously experience them in substitution and to return them, transformed by his own experience, to the patient. Within this context, it also means the ability to track down the patient's possibilities for development that lie hidden in his psychopathology, to shed light upon them, and to support them against any possible resistance. Finally, I would like to mention the "cognitive respect" for the psychosis. Nothing is so incapable of empathy in its language that it would not also be unique and individually stimulating to us, and no hour of therapy is so boring in its recidivism that it cannot every time offer something as new and unexpected as life itself.

2. The affective closeness to the psychotic patient, which Arieti calls "relatedness", has already been represented for many years by psychoanalysis, even in the treatment of the severely neurotic patient, as a partial possibility. Along with Cremerius, I cite the "principle of emotional experience."

I myself see the affective closeness above all else in that capability of the therapist for partial identification with certain sides of the psychotic person that do not seldom appear in the manner in which we dream about our patients and which makes it possible for us to go through the situations of dangers in symbol, fantasy, and dream, situations which the patients are at the mercy of, without our being threatened by such closeness.

If the therapist is not threatened by the affective closeness and the partial identification that results from it, but rather is only "existentially challenged", then he can create progressive representations of coping out of the negative images of the psychosis and can convey them to the patient.

Affective closeness is consequently a source of imagination and the formation of symbols. It is the origin of that “double nature” of the therapeutic imagination that, on one hand, follows the metaphorical language of the patients, thus accepting it seriously and without adulteration, and, on the other hand, brings about a positive change through its own symbols.

Affective closeness is in conflict only in dialectical terms with rationalization, with conceptually articulated interpretation, with expansive reflection.

3. The Positive Distance

Every person, admittedly including the psychotherapist, has his problems and conflicts. Does he know them? Has he dealt with them? In the first place, the therapist's conflicts that have existed and been dealt with create that special *sensitivity* which is important for the deeper understanding of the psychosis and which I also would like to designate as a “positive affinity” for the illness. In the second place, on the other hand, they weigh upon the relationship, especially if they remain unconscious to the therapist without supervision. Then the patients are faced with those *introjections* (for example, the unconscious therapeutic aggressivity) that are not experienced by him as such but rather as his own impulses (Searles). Thus in every case, that attentive and constant *self-examination* and *self-consciousness* which Sullivan has already emphasized is necessary with the therapist. It works in the inverse direction of closeness, it creates that *intersubjective* distance which protects the encounter from any danger of mutual entanglement and lends it rather the expansive breadth of reflection. This fundamentally holds true for any psychotherapy, but especially for the treatment of psychotic people whose “*ego boundary*” is fragile (Federn) and whose symbiotic potential is high in spite of all autism.

Positive distance correspondingly means that the therapist learns to work “free of countertransference” in certain situations. Freud expressed early on that the best analyst is the one who can work without countertransference. Today, on the other hand, we know that countertransference is an important engine of the relationship. If, however, it is understood in the more narrow original meaning as a projection of earlier unconscious experiences upon the patient, and if such experiences are of the negative variety, then they can weigh upon the therapeutic relationship. Let us think, for instance, of the feelings of helplessness or of boredom which may exist in the face of stubborn psychotic resistance with the therapist if he himself has to deal

with a depressive fund of his own life. His self-knowledge and self-meditation, however, are capable of producing once again that agreeable attitude of the calm distance that resolves any mutual mixing of the problems.

An attitude of positive distance also means that the therapist controls the manner and the degree of the affective closeness that connects him with his patient according to the latter's needs and can often be adapted to the patient's fear. For example, should a therapeutic dream that does indeed shed light upon a problem and spread optimism be communicated or be kept silent? In a certain situation, can a decisive statement be ventured? Behind the "technical problems" which are then to be discussed hovers the attitude of the therapist which is a cause of the fact that sometimes, interpretations that may appear similar can have different results, depending upon the character of the therapist.

I would like to close here. The first three Symposia were the point of departure for a pioneering development in psychiatry and made me decide to remain loyal to the project of the psychotherapy of schizophrenic people for half a century and to dedicate the majority of my therapeutic and scientific energy to it.

References

The literature of all of the lectures cited in the text is contained in the three cited Symposium volumes, edited by G. Benedetti and C. Müller. In addition to these, I would also like to mention additional works by Peciccia, Navratil, Searles, and Sullivan.

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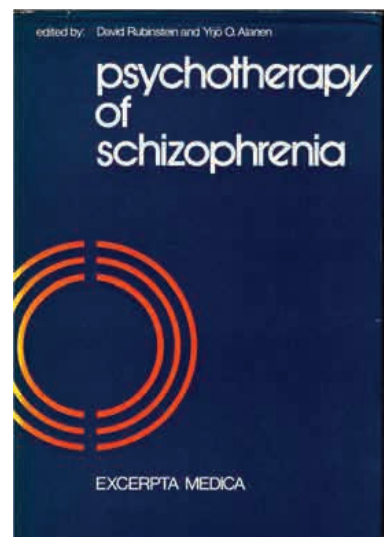
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*Yrjö Alanen,
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Book of Turku Symposium 1971

CHAPT. 4 PHOTOGRAPHS



*Otto Will,
Symposium Turku 1971*

4. The IVth ISPS Symposium In Turku, Finland in August 4 – 7, 1971

Yrjö O. Alanen

Preparations

Five years had elapsed in 1969 without any new plans for further gatherings since the first three ISPS symposia. This may have been influenced by a certain amount of frustration due to partly unrealistic expectations invested in long-time psychoanalytic psychotherapies of schizophrenic patients - sometimes began with rather "heroic" starting-points. At the same time, the position of neuroleptic drugs as the general treatment mode of this disorder was confirmed. *Christian Müller* dealt with these matters in his Turku presentation to which I will return later. However, the interest was by no means extinguished and also new ways of psychotherapeutic treatment had been developed.

In this situation, I received a telephone call from my close friend and colleague *Kauko Kaila*, one of the Finnish psychiatrists who had received psychotherapy training in Switzerland during the 1950s and taken a continued interest in the care of schizophrenic patients. Kaila as well as his colleagues *Martti Siirala* and *Allan Johansson* also participated in the earlier ISPS symposia. Kaila had communicated with *Müller* whom I also knew well after his visit in Finland a few years earlier. Being aware of the interest those of us at the Turku University Department of Psychiatry had in the psychotherapy of schizophrenia, they suggested that the symposium be held here. As a young and newly appointed head of this department, I regarded this proposal both as an honour and as a great pleasure. An international organizing committee of ten members as well as a smaller local organizing group (besides myself, *Dr. Viljo Rökköläinen*, *Dr. Simo Salonen*, *Mrs. Aira Laine*, psychologist and *Mrs. Outi Kangas*, secretary) was promptly established and the preparatory work for the symposium began.

The inquiries I sent to well-known schizophrenia psychotherapists from Europe and America showed that the interest towards this kind of

symposium had grown greatly. Compared with the earlier symposia, two changes were made. While the participants of Swiss symposia were, with a few exceptions, residing in Central European countries, I also made contacts with many American psychotherapists, most of them I already knew from my earlier study year in the United States. This also led to the result that the main language of the symposium became English, instead of the earlier German and French. The other change was the extension of the programme to include not only individual psychotherapy and theoretical issues related to it, but also family therapy and research, as well as experiences of therapeutic communities established for the treatment of schizophrenic patients. However, we continued - even if somewhat extended - the restriction of the amount of participants, familiar from the symposia held in Switzerland in order to maintain a rather intimate atmosphere. The amount of participants was fixed at 60, 15 of them being from the host country.

While asking for the views expressed by the members of the International Organizing Committee, I still had a rather free hand in the planning of the symposium. For the invitation of the speakers, we received several small grants from various (in total, 12) pharmacological companies - a fact which exposes the financial dependence of the medical field, including the university departments, to this kind of support. A congress on psychotherapy was not, of course, their first selection, but was still regarded as a part of their public relations activities about which we expressed our gratitude.

I invited several well-known psychotherapists from the U.S., then the leading country in the field, beginning with my earlier teacher *Theodore Lidz* from Yale University. I also contacted the Psychotherapy Section of the World Psychiatric Association. *David Rubinstein*, a family therapist and the secretary and treasurer of the section, appeared to have a very active interest in the symposium. Together with Rubinstein and facilitated by his contacts, we afterwards edited a *book including all symposium presentations*, published by Excerpta Fennica (Rubinstein and Alanen, 1972) - according to my opinion, printed even in a too elegant and expensive way. Cuban-born David came to Turku with his own family - a luxuriant Mrs. Rubinstein, impressing all the symposium participants by her manifold necklaces and rings, and four kids.

Dr. *Denis Leigh* from Great Britain, Secretary General of the WPA, also showed his keen interest in the symposium, encouraging us through his appearance in Turku. Other British participants included, among others,

some colleagues familiar to me from my recent visit there. I also wrote to *Ronald D. Laing* inviting him to come to Turku but received a refusal (as far as I remember, the only one!): Laing wrote to me that he could not promise to come to Turku in 1971 because he did not know where he would that year. Later I heard that he had been in a Buddhist Monastery in Thailand.

From the Central Europe, the “founding fathers” *Gaetano Benedetti* and *Christian Müller* were self-evident lecturers. A group of German psychiatrists, who had participated in earlier symposia, also came to Turku to give presentations. This led us to the establishment of a German-speaking sector in the programme. The situation was worse with regard to the French participants: there were only two of them, and they did not have presentations in the symposium. We found it reasonable to translate the German presentations into English for the symposium book. However, the diminishing amount of Central European participants was also a problem in the later symposia, except for those held on their own soil.

The Scandinavian and Finnish therapists were naturally well represented, even if I had the unpleasant role to refuse many requests here. I was glad that the restriction of the amount of participants did not continue in the following symposium, held in Oslo.

The geographical distribution of the participants covered an area from Budapest, Hungary to Lima, Peru. Dr. Leigh told me that we should have also invited some African colleague to join our group. Maybe he was right. Anyway, we, as the members of the local organizing group, were very pleased by the activity and enthusiasm of the symposium participants and, even helped by weather warmer than the average during the Finnish summer, we were left with very pleasant remembrances of this event.

Preparations

The presentations in the symposium – as well as in our proceedings book – were divided in four parts: *I. Basic and Theoretical Issues; II. Individual Psychotherapy; III. Family Psychotherapy and Research; and IV. Psychotherapeutic Community and Related Subjects*. The book also includes my introductory address and a verbatim report on the panel discussion concluding our programme.

I will begin with *my introduction*. Entitled “The Place of Psychotherapy in the Psychiatric Approach to Schizophrenia,” it dealt with the problem why psychotherapy not only occupies a rather peripheral place but is actually subject to rejection in the treatment of schizophrenia. For the therapists, participating in the symposium, psychodynamic approach to schizophrenic patients is an empirical fact, verified in our practice. In the schizophrenic withdrawal and disorganization of the personality we see an attempt by the patient to preserve a minimum of security and need satisfaction in an environment that has become excessively frightening to him – “an individual who is perhaps more vulnerable than the average and who has in any case grown up amidst anxiety-producing modes of human interrelationships.” We are able to help schizophrenic patients, or at least a part of them, to improve or recover. I found a complicated conglomeration of causes of the situation:

- our scientific-medical tradition, such great victories in the investigation and treatment of numerous other illnesses. The psychotherapeutic ways of thought are often difficult to comprehend and even experienced as “unmedical;”
- unconscious defences, both individual and collective, adding to the difficulty to integrate the knowledge about man gained through psychodynamic study with biological knowledge and to examine the interrelationship between these two;
- connected with this, a tendency to isolate these patients, not totally from society as often previously, but psychologically, by emphasizing the dissimilarity between them and other people, including ourselves;
- reliance on the drug treatment to avoid encountering the schizophrenic patients’ deep-rooted problems;
- the high number of schizophrenic patients.

I also referred to a larger resistance factor, supposedly the most fundamental of all: the denial of our common guilt, springing from the responsibility we all have for another - the most important reason why the obvious influence exerted by parent-child relationships on the child’s development and the part played by them in the genesis of various mental disorders are so difficult to perceive and the knowledge of them so difficult to be adopted.

The same kind of problems – even more critical today than thirty years ago - were dealt with by some other speakers, in an especially concrete way by

Christian Müller. In his treatise “The problem of resistance to psychotherapy of schizophrenic patients,” Müller examined the reasons why the number of schizophrenic patients receiving individual psychotherapy or analytically oriented group therapy has diminished in Europe. He turned toward the unconscious motivations and resistances of the therapists themselves. The key-word he found was narcissism, not only by the patient but especially by the mobilisation of claims to omnipotence engendered within the analyst by the patient. Such claims serve in the service of the physician’s primary narcissism and the unconscious fantasies satellite to this. According to Müller, the current caution in the application of psychoanalytic methods in schizophrenia may have its roots here: in the fear of frustrations which the therapist has not overcome in himself; his fear of uncontrolled aggressivity as a reaction to narcissistic insults; i.e., in the therapist’s countertransference problems leading them to protect themselves of such experiences through new duties and avoidance of new therapeutic endeavours with schizophrenic patents.

Müller also referred to the influence of rebellion against powerful father figures personified by the representatives of the old Kraepelinian psychiatry. He also showed understanding for the problems of these psychiatrists: “Let us imagine what it would mean (for them) were we able to furnish an absolute proof that schizophrenia would be determined solely on the basis of biographical factors!” The shock would be calamitous: many measures that were in use over the course of years would reveal themselves as horrible mistakes. They would react according to the principle: *what may not be, cannot be*. Müller also criticized the fashionable opposite trend to deny the disease character of schizophrenia and the easy solutions of the problem of madness achieved through such fancies. Referring to his teacher Ernst Blum, he emphasized “the counter-magic of organic” as well as “the counter-magic of political”, both of them serving as defensive pseudo-solutions to the problems of schizophrenia and its treatment. At the end of his presentation he reminded us all (including himself), “not to close our eyes against the forces governing within each of us, and within the scope of our continuing self-analysis, constantly to test as well our relationship and encounters with the schizophrenic”.

The other central presentations in Part I. were those by *Theodore Lidz* (“Schizophrenic disorders: the influence of conceptualizations on therapy”) and *Otto. A. Will Jr.* (“Psychotherapy and schizophrenia: implications for human living”). Two characteristics were common for both of them: a

humanistic spirit and the emphasis on technical problems of the therapeutic relationship, differing from the therapy of neurotic patients through its more interaction-marked character. *Lidz* repeated the family findings of his research group (*Lidz et al., 1965*), their inference being that “the cardinal therapeutic task with schizophrenic patients lies in releasing the patient from the bondage of completing a parents’ life, or in bridging the schism between his parents, to enable him to become a person of his own right, investing his energies in his own development and his future rather than in coping with the problems of the preceding generation.” He warned against an early and forceful use of interpretations, because the major focus of therapy lies in individuation and reliance upon the self. He also expressed his doubt that conjoint family therapy – as useful as it may be by preparing the patient’s way for the revaluation and intrapsychic reorganization of the parental introjects – could by itself undo the intrapsychic distortions. For this, individual therapeutic relationship is needed. However, *Lidz* also emphasized the significance of residential treatment and questioned the adequacy of individual psychotherapy without provision of social, emotional, and cognitive educational or re-educational therapy, particularly in those patients whose difficulties are more developmental than regressive in nature. He also concluded that the diminishing interest in the psychotherapy of schizophrenic disorders is at least partially due to discouragements stemming from following faulty directives.

Will told us of his first contacts with schizophrenia patients, then named as cases of dementia praecox with its implications of organic deficit, disease and deterioration. Gradually he became interested in the patients as human beings: “I shall never forget what it meant to me personally as well as professionally to discover that ‘everyone is much more simply human than otherwise,’ as expressed in the well-known thesis of the great teacher, Harry Stack Sullivan (1953). There is now, *Will* emphasized, evidence to support “the view that schizophrenia is a paradigm of fundamental aspects of human living, and that psychotherapy is not only a treatment procedure, but is a method for the study of those fundamentals displayed in distorted form – and yet in startling clarity – in schizophrenic behavior.” *Will* then examined comprehensively phenomenological, etiological and therapeutic questions connected with schizophrenia, illustrated by the treatment of a female patient. He especially emphasized the topics of the sense of self, of relatedness, and of hope. “I hold to the view that the human relationship is the essential ingredient of human survival, growth, development, and continued existence,” *Will* concluded, summing up his speech: “The

interpersonal is not all of man's life but we ignore its importance to our peril ... Our task is not to decide that psychotherapy or human relatedness are necessarily or useful – or not – but to determine how these may be used to further the realization of a human being's growth."

Other presentations in Part I included those by *Claus B. Bahnson* (U.S.A.), *Torsten Herner* (Sweden), *Esther Bloom* (Denmark), and *Thomas Freeman* (Northern Ireland, U.K.). I was impressed by presentations of two younger psychoanalysts - even if schizophrenia may not have been the most central topic in them. *Michael A. Woodbury* (U.S.A.) had as his topic "The Abraham complex: of filicide, war and psychosis:" "War can be considered a social institution which among other things keeps under control filicidal and reactive patricidal impulses" (even by the "contract:" let us not kill our sons but one another's: let us spare our own sons to that they can defend us against other men's sons!). *Matti Tuovinen* (Finland), working in the field of forensic psychiatry, examined the topic "Schizophrenia and the basic crimes;" the basic crimes being murder, incest, and cannibalism (the last one, however, was left outside of the presentation "because of the lack of opportunity to study a case"). According to Tuovinen, murder often has also a certain "constructive" aspect, from the point of the murderer's ego, as an attempt to intrapsychic adaptation used, e.g., to avoid a mental illness.

Part II, dealing with individual psychotherapy, was begun by *Gaetano Benedetti* ("Psychosynthetic countertransference in individual psychotherapy of schizophrenia"). His main emphasis was the importance of the countertransference, a topic which also played a central role in many of Benedetti's later presentations and writings. Psychotherapy with schizophrenics is a combination of two methodological approaches: 1) A psychoanalytic technique modified, in contrast with the analysis of the neuroses, and 2) an attempt at a psychosynthesis. "He is in us and we are in him", Benedetti pointed out and raised the synthetic function based on the interactional relationship as the central agent in the development of the schizophrenic patient's personality. He also draw our attention to the dreams of the psychotherapist: they may be an important indicator of the unconscious countertransferential processes.

Silvano Arieti's lecture ("Psychodynamic search of common values with the schizophrenic") relied greatly on the experiences of Frieda Fromm-Rechmann and other therapists of the "Washington school," leading then to critical examinations of extremist views on the nature of schizophrenia.

Arieti pointed out, e.g., that the etiological factors are not restricted to the influence of a very unfavourable early family environment; the patients also have a special propensity for responding strongly only to the adverse aspects of environment. He especially criticized Laing's opinions. "We must thus conclude that the schizophrenic psychosis is not a normal reaction to an abnormal situation, as some authors, for instance Laing, imply. *It is an abnormal way of dealing with an abnormal situation* (italics by Arieti)."

Two younger Scandinavian therapists, *Britta Hegethorn* (Sweden) and *Pirkko Siltala* (Finland), as well as *G. Ammon* (Germany) concentrated in case histories. Ammon's technique had influences deriving from Rosen's "direct analysis." *Siltala* told us of a long and successful therapeutic relationship with an especially ill male patient. I admired her ability to preserve her therapeutic role and attitude even while allowing herself to expand the therapeutic sphere by contacting the patient's mother – originally hostile towards the therapist – as well as to continue the therapy hours during her maternity leave at her home and allowing the patient to realize his hopes to see the therapist's baby boy with whom he in part unconsciously identified himself. This is an example of the exemptions from usual restrictions sometimes beneficial in schizophrenia psychotherapy – Benedetti told in his presentation of a therapist, supervised by him, who once with good result suggested to his patient a psychodrama, wherein they would temporarily exchange roles: the patient was to sit on his chair, his on hers. Part II was concluded by *Martti Siirala's* philosophical treatise the essential aspiration of which was expressed in its title: "Psychotherapy of schizophrenia as a basic human experience, as a ferment for a metamorphosis in the conception of knowledge and the image of man." From his ethical starting-points Siirala pointed out that insight into individual schizophrenia needs enlargement to comprise the collective isomorphic phenomena: "Whenever a human dilemma does not meet any center of common responsibility ... it is bound to move into direction of vicarious responsibility, devoid of the solidarity of any common network."

Part III of the symposium, *Family Psychotherapy and Research*, was, according to my opinion, especially interesting, bringing to our knowledge findings of the psychodynamic family research strongly emerged during the preceding ten to fifteen years. This concerns, above all, two investigators, closely related to each other, *Helm Stierlin* and *Lyman C. Wynne* (both of them then working at the National Institute of Mental Health near Washington). Their presentations (Stierlin: "Family dynamics and separations patterns of

potential schizophrenics;” Wynne: “The injection and the concealment of meaning in the family relationships and psychotherapy of schizophrenics”) combined both theoretical and clinical viewpoints.

In the beginning of his discourse, *Stierlin* stated that there are two more or less integrated etiological pathways leading the potential schizophrenic to his final breakdown: the pathway of calamity and inept parenting, and the pathway of psychological exploitation. He then focused on the latter and presented – as I understand, for the first time - his concept of *transactional modes* which dominate a family life during given periods, all of them, when operating in excess, implying a traumatization and/or psychological exploitation of the child. The transactional modes are the modes of binding, delegating, and expelling. The binding may operate on three levels which can be formulated and named also with terms closely connected with the psychoanalytic structural model: id-binding (infantilizing the child by offering undue regressive gratification), ego-binding (the parent substitutes his own – distorted as well as distorting – ego for that of the child), and superego-binding (the child is trained to experience any betrayal of loyalty – as exemplified in his wish to separate – as a crime against the parent). The mode of delegating gives more space to the child, who still is held “on a long leash:” it combines the two meanings of the Latin word, *de-legare*: to send out, and to entrust with a mission. The mode of expelling means an enduring neglect and rejection of the child. The modes were also illustrated by a case history.

As a psychoanalyst and family researcher, I found – and still find – these transactional modes, more detailed examined in *Stierlin’s* accompanying works (*Stierlin, 1974*) very instructive and useful in understanding the interactional dynamics in the families of many schizophrenics, and in my mind I have even somewhat deplored that they seem to have fallen more into background in his later work. Consider, e.g., the role of the mode of delegation in the fate of the Australian pianist David Helfgott, described in the well-known film “Shine!”

Wynne’s description of the injection and concealment of meaning can be seen, as it were, as illustrations of the attribution dynamics included in *Stierlin’s* mode of ego-binding, with many clinical examples. *Wynne* also refers to *Schatzman’s* (1971) study of the painful ways developed by the father of Dr. Daniel Paul Schreber, the object of Freud’s famous treatise, to control the behaviour of his children (even more thoroughly described by

Niederland, 1984), thus illustrating the links between the intrapsychic dynamics, as examined by Freud, and the family dynamics. In his concluding discussion of implications for psychotherapy, Wynne especially emphasized the complementary roles within the families, thus paving the way for systemic approaches to family therapy. “The first task of parents and therapists alike is to help establish a trustworthy relationship within which there can be reciprocal interchange, verbal and non-verbal.”

David Rubinstein's presentation (“Clinical issues in family therapy of schizophrenia”) gave to us a description of his own way as a psychotherapist of schizophrenic patients, begun as a pupil of Rosen, selecting a chronically ill young schizophrenic to live in his family and experiencing the most difficult impact this kind of patient may have on the family life, and developing to a systemically oriented family therapist. *In my own presentation*, I spoke about the benefits of family therapy in hebephrenic schizophrenia, illustrated by a case history; *Heimo Salminen* (Finland) also had a case report dealing with the family therapy of a schizophrenic patient; *Michael B. Conran* (United Kingdom) dealt with the relationship between blame and hope, based on his experiences from Villa 21 in Shenley Hospital near London (cf. later); and *Helmut Bach* (Germany) with the preference for analytical family therapy of a juvenile psychotic patient. *Michael A Woodbury* (U.S.A.), working in the field of community psychiatry, examined more complex socio-cultural processes and transitional concepts linking individual, family and community dynamics in an interesting way.

This section also included two expressly research-centred presentations. *R.D. Scott* and *A. Montanez* (U.K.), from Napsbury hospital, operating under the National Health Service, had compared with each other the parents' view of themselves and the patients' view of their parents in a “community centred” group of schizophrenics, spending less than 70 % of the 2 years after first admission in hospital, and in a “hospital-centred” group in which the patients spent more than 70 % of the two years after first admission in the hospital. It appeared that in the community centred group patients confirmed the parents' view of themselves (“tenable patient-parent relationships”) while there typically was a difference between the parents' view of themselves and the patients' view of their parents (“untenable patient-parent relationships”) in the hospital-centred group. In the latter group, there was a heightened danger of continuing hospitalisation based on psychological rejection from the part of the family members (the “closure” as aptly described by *Scott and Ashworth*, 1967). The implication for therapy was

that active family-centred treatment should be directed to the hospital-centred group. "We reserve what resources we have for those who certainly require them, the hospital-centred patient and his parents." *Stein Bastiansen* and *Einar Kringlen* (Norway) gave a preliminary report of their study of children of two psychotic parents; the sampling of parents being based on the Norwegian Psychosis Register and information of the children - besides various official records - on personal investigation. The result was that, even with age correction, the frequency of psychotic subjects among the children did not exceed 25 %. There was no significant difference between various diagnostic combinations of psychosis in the parents. Besides psychotic children, a great variability of normal (more than one third), neurotic and "psychopathic" offsprings were found.

Part IV, *Psychotherapeutic Community and Related Subjects*, may be characterized as probably the most "virginal" area in the symposium. During the panel discussion concluding our programme it was stated that despite a general interest very few studies of the results of the work in therapeutic communities had been published.

The section was begun by *Loren R. Mosher* (U.S.A.), the emerging pioneer in the establishment of therapeutic communities outside the system of medical organizations. He presented - as far as I know, for the first time - the principles and research design of the *Soteria project*, recently begun by *Leonard Goveia*, *Alma Menn*, and *Mosher*. Mosher told us that the project will test the developmental crisis orientation to an initial episode of schizophrenia. The therapy will be given "by indigenous, non-professional, specially trained personnel ('guides') to a group of schizophrenic patients living with staff, in a comfortable 16-room home in the community, which we call Soteria house." Mosher emphasized that the disruptive schizophrenic episode is also believed to have unique potential for reintegration-reconstitution if it is not prematurely aborted or forced into some psychologically 'strait-jacketing' compromise. The personnel is selected from persons who seem to have the potential ability to 'tune in' the patient's altered state of consciousness, without no "procrustean" theory of schizophrenia. In the study, much emphasis will be placed on the self-report of the patients. The patients will be followed for two years after discharge, and a control group is formed from a psychiatric ward in a local general hospital. - As far as I remember, the first reactions to Mosher's plan were somewhat confused; the Soteria project was not mentioned in the concluding panel discussion.

Problems and difficulties inherent in the establishment and activities of therapeutic communities in the frames of hospital environment were a topic recurring in many presentations, including those by *A.A. Fischer* (the Netherlands), *C. Roccella* (Italy), *J. Füredi* and *M. Kun* (Hungary), and *Kauko Kaila* (Finland). The rigidity of the organization, often in the form of authoritarian attitude of the leading officials (sometimes physicians, sometimes not), resistance based on the difficulty to understand a therapeutic approach deviating from the usual medical model were among the factors mentioned, as well as intrigues both outside and within the ward community. *Fischer*, working at the H. C. Ruemke Clinic connected with the University of Utrecht, dealt with conditions, personal and organizational, which he had found crucial for success or failure of a therapeutic community, emphasizing, e.g., the need for a constant, optimal tension which should remain between social and real relationships and therapeutic relationships. His conclusions were rather pessimistic with regard to the possibilities to make a therapeutic community succeed as a part of a bigger institution like a mental hospital. The therapeutic community "must be outside a medical system of organization, consequently outside a hospital", and it "must develop in a situation that compares maximally with normal living conditions," *Fischer* inferred.

Simo Salonen (Finland), working at our Turku clinic, had a more optimistic tone. Unconsciously, he had seen the therapeutic community as a means of realizing his own omnipotence fantasies, or as an extension of himself, as it were. In connection of the following panel discussion *Salonen* brought forward his interesting observations of the patients' fragmented transferences manifesting themselves in their relationships with different members of therapeutic community. An internal integrative process of the therapeutic community may then lead to a situation where the patient's fragmentary and obscure transference processes begin to appear more integrated. In their presentation "On the taking of a medicine" *Michael B. Conran* and *S. T. Hayward* gave us a psychoanalytically oriented "snapshot" of the interrelational work of the staff in Villa 21 at Shenley hospital near London, in which *Conran* had developed a therapeutic community which consciously followed the family structure. *W. Bister* (Germany) told us of results of psycho- and sociotherapy with schizophrenics in a night clinical ward in Berlin, and another German therapist, *M. Pohlen* described his study dealing with a new organizational mode for short-term psychoanalytic group analysis in a clinical setting.

The discussion of the activities and problems of therapeutic communities continued in the *Panel discussion*, chaired by *Otto A. Will*. Experiences were further described by, e.g., *Jarl Jørstad* who, together with Endre Ugelstad, organized the next ISPS symposium. He described the work at the Dikemark Hospital in Oslo, Norway, opposing Fischer's exacerbated view of the impossibility to make a therapeutic community succeed as a part of a hospital. *Christian Müller* said that he did not believe that the principle of therapeutic community has a real specific action, a view opposed by *Fischer* and *Salonen*. The discussion then went on to the question of how to define the term therapeutic community. *Will*, himself Director of Psychotherapy at Chestnut Lodge sanatorium in which many patients stayed for years⁶, mentioned examples of the very varied use of this term: he had even visited a ward, "like an old-fashioned railway station," in which the median stay of patients was less than 7 days. The psychiatrist in charge still called his ward "therapeutic community." *Stuart C. Miller*, from the Austen Riggs Center, U.S.A. said that the goals of the community they have – also with long-time patients in intensive individual psychotherapy – would probably be better described as anti-antitherapeutic than as therapeutic. I had the opportunity to introduce the use of the term "*psychotherapeutic community*" adopted at our Turku clinic, to make a difference from a therapeutic community of Maxwell Jones' type, in which the main emphasis was not put on psychotherapeutic relationships. Mosher provoked panel members by asking if anyone can show him a study that therapeutic community, however defined, does anything for schizophrenics that cannot be done without one? He himself knew only two studies in which results of therapeutic communities were compared with those of more traditional hospital ward, both of them unsatisfactory in their design.

A ladies' committee (Mrs. Hanni Alanen. Mrs. Kaija Kaila and Mrs. Varpu Siirala) planned the *social program* of the symposium together with the organizing group, the absolute draw of which was a cruise in the beautiful Turku archipelago, with hundreds of islands, to the island of Seili, in which the eldest mental hospital in Finland had been situated (now changed to the Institute for Archipelagic Research of the University of Turku). The weather

⁶ The first book with a comprehensive examination of the milieu of psychotherapeutic hospital treatment, *The Mental Hospital* by Stanton & Schwarz (1954) dealt with Chestnut Lodge.

was kindly disposed to us. The warm August evening, gradually getting dimmer, as well as the old wooden Seili church impressed many of the participants. The enchanted Mrs. Adele Wynne – having American-Swedish background – experienced herself to have been brought in the middle of an Ingvar Bergman film.

Afterthoughts

How to describe the influence of the symposium? It certainly increased the interest in and respect for psychotherapeutic activities with schizophrenic patients in Finland and in other Northern European countries, even if the restriction of the amount of participants may have somewhat diminished this. At our department, we have got a place, at least preliminary, in the “world map” of schizophrenia investigation and therapy, and the comprehensive psychotherapeutically oriented Turku Schizophrenia Project, began a couple of years earlier, received a strong stimulus for its further work. After the symposium, *Otto A. Will* led a psychotherapy seminar at our department, followed by *Helm Stierlin* the next year and after them many other well-known therapists and researchers.

It was also obvious that the international community of schizophrenia psychotherapists greatly enjoyed this opportunity to discuss their experiences with each other and strengthen their mutual relationships. The diminished interest, referred to at the beginning of this account, was not perceptible in the atmosphere of the symposium. This was also confirmed by the decision to continue the series of symposia in the future at three years' regular intervals.

Compared with earlier ISPS symposia, there was a somewhat more critical tone with regard to questions dealing with individual psychotherapy. However, Lidz, Will and Benedetti examined therapeutic relationships with schizophrenic patients and the techniques suitable for them in a very constructive and deepening way. The section dealing with family therapy was – at least for me - the most innovative part of the symposium while the study of therapeutic communities appeared to be in its early phase, including Mosher's initial presentation of the courageous Soteria plan. Regrettably, resistance factors referred to above have later greatly hindered the family-centred work based on psychodynamic understanding, so promising thirty or

forty years ago. One can understand the opposite reaction on the part of, e.g., parents' associations, supported by psychiatrists with restrictive neurobiological views, to the family findings – at least with a superficial acquaintance with them. However, one should notice that the purpose of psychodynamically oriented family investigators has always been to help both the patients and their families. Later, the systemic point of view has led to a more balanced view to the family interrelationships: that all interactions among different members in the family are two-way processes, and at the same time a part of the dynamics of the larger family circle. Parents influence their children, and children, with their different innate inclinations, influence their parents. In addition the importance of genetic vulnerability, besides the problems of disordered environments of growth, was referred to in several symposium presentations. This is certainly a wider view to vulnerability factors in schizophrenia than the views of many neurobiological investigators of today for whom the word “environment” only refers to physical factors in work during the mother’s pregnancy or childbirth.

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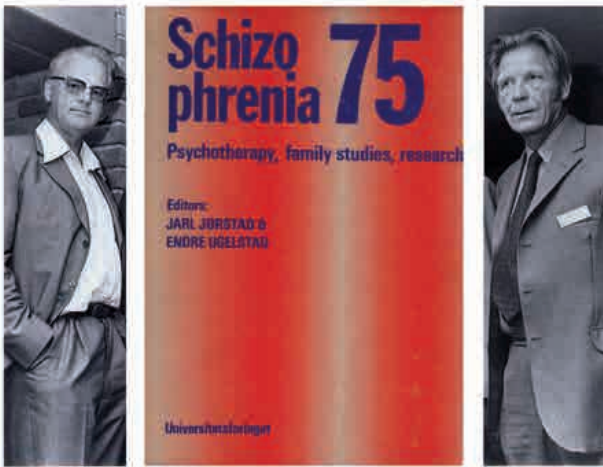
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CHAPT. 5 PHOTOGRAPHS



*Chairmen and
book of Oslo
Symposium 1975*

*Photo from Oslo
Symposium 1975.- From
left to right, Jarl Jørstad,
Yrjö Alanen,
Helm Stierlin,
Theodore Lidz and
Endre Ugelstad
All of them ISPS
Honorary Members.*



CHAPT. 5 PHOTOGRAPHS



*Oslo Symposium 1975
Esko Orma, Heta Orma, YrjoAlanen,
Hanni Alanen, Pekka Tienari*

5. The Vth ISPS Symposium In Oslo, Norway, August 13 -17, 1975

Jarl Jörstad, Svein Haugsgjerd and Bjørn Østberg

Background

The development within the Norwegian psychiatry over the last few years has served as a background for this 5th International Symposium On Psychotherapy of Schizophrenia in Oslo. Interest in learning more about psychotherapy was increased and created demands from younger and younger residents and psychiatrists for better teaching and training. This resulted in a dramatic change in residency training in psychiatry where the Psychotherapy Committee in the Norwegian Psychiatric Association formulated the new demands: Every psychiatric resident had to have 100 hours supervision, once a week in the therapist-patient relationship and the basic principles of psychodynamic psychotherapy. The supervisors should have a psychodynamic or psychoanalytic background, including their own psychotherapy/psychoanalysis. These demands provoked strong resistances from many of the professors who were chairmen in the teaching committees, but they could not stop the development and new committees were constituted.

At that time, most residents were working in mental hospitals, most treating severely disturbed patients, many of them schizophrenics. The need to learn more about how to treat these difficult and challenging patients was one background for the symposium. Another contributing factor was the arrangement of two to three seminars on psychotherapy once a year. Eighty to 100 participants from all over Norway met some of the pioneers in psychotherapy from other countries, particularly Switzerland, Great Britain and the USA.

Some of us also had been able to study at some of the best teaching centers abroad and to come into contact with outstanding psychotherapists, some of whom we could invite to the Symposium in Oslo.

The Norwegian arrangement committee of the Symposium in Oslo was: Endre Ugelstad, chairman; *Jarl Jørstad*, co-chairman; *Svein Haugsgjerd*, secretary; *Willy Jensen*, treasurer; *Bjørn Østberg*, postsymposium seminars; *Oddbjørg Jørstad*, social program, and *Nils Retterstøl*, *Helge Waal*, *Einar Kringlen*.

More than 100 participants from 15 different countries attended the Symposium - all active in psychotherapeutic work and research. In addition to lectures and discussions in plenum and in sections, a great deal of work and exchange of experience took place in a number of workshops during the afternoons.

Compared with former symposia in 1956, 1959, 1964 and 1971, this symposium found that the quest for a clearer comprehension of factors operative in intensive psychotherapy of schizophrenia was continuing. However, there were also new tendencies within the scope of psychotherapeutic and social treatment of schizophrenia. Our insight was deepened through family studies and the development of different forms of family therapy. We also gained experience from milieu-work in institutions and through social-psychiatric viewpoints.

The different aspects of the Symposium were concentrated in three parts:

I Basic issues and psychotherapeutic experiences in different settings.

The contributors were: *Gaetano Benedetti*, *Beatrice Foster*, *Ruth* and *Ted Lidz*, *Donald Melzer*, *Christian Müller*, *E. M. Podwoll*, *Viljo Rökköläinen*, *Simo Salonen*, *Clarence G. Schulz*, *John Strauss et al.* and *The Arezzo Group*.

II Family studies: Implications for treatment.

The contributors were: *Yrjö Alanen*, *M. A. Bremer-Schulte*, *Michael Conran*, *Stephen Fleck*, *Luc Kaufman*, *David Rubinstein*, *R. D. Scott*, *Maria Palazzoli Selvini* and *Helm Stierlin*.

III Research projects.

The contributors were: *John G. Gunderson*, *Edgar Heim* and *Enar Johnsen* with co-workers, *Maria Orwid et al.*, *Alma Z. Menn* and *Loren R. Moshier*, *Clarence G. Schulz*, *Endre Ugelstad*, *Lyman Wynne* and *Margaret Singer*.

Abstracts of some of the central presentations are mentioned here:

I Basic issues and psychotherapeutic experiences in different settings.

Gaetano Benedetti, whom we knew from previous seminars in Norway, started with: *Curative factors in psychotherapy with schizophrenic patients*. He felt this was the very scientific core of psychotherapy. Curative factors are those that make a new openness of communication between patient and therapist possible. He considered four points of central importance: 1. The dynamics of the therapist's unconscious as shown by some of his dreams. 2. The therapist's fantasies. 3. The mirror phenomenon, which moves in both directions. 4. The integration of love and aggression in the patient and in the therapist. Benedetti illustrated these four points with a couple of dreams of the therapists and vignettes from therapies. It is not the dream itself which is the curative factor but the attitude of the therapist which is surely more than love. It is also symbiosis and service to the patient. They also convey to the patient how much the therapist is involved with him/her. Secondly, the patient experiences through dreams that he/she is being meshed and confused with an alien other world, which, however, is substituted through the unconscious symbiosis with the non-alien therapist. The curative effects rest upon the capacity of the therapist, first to share truly and sincerely the images of the patient and second to transform them slowly by the ferment of the therapist's presence, to permeate them with his/her own fantasies.

An example of the mirror phenomenon is a patient who says: "When dancing, I need someone looking at me in order to be sure that I really exist."

Integration also occurs in psychotherapy by showing the patient his/her destructive impulses, unusually concealed in his/her projections onto the outer world, in his/her delusions of persecution. Healing is not so much the patient's cognitive realization of his/her own aggressive impulses but the integration in a positive frame of reference. This partly happens through the loving attitude of the therapist and through pointing out to the patient how many positive aspects of him/herself are destroyed by his/her destructive impulses. The integration of the destructive impulses within the many psychological factors and experiences of the past, which determined them, is also important. Aggressive impulses will regularly be transferred to the therapeutic relationship. The tranquility of the therapist in encountering such fantasies, directed against him/herself appeared to be the first support of the patient and the aggressive impulses slowly become less and less dissociated. Fusion of love and aggression in the patient occur, first of all, through the therapeutic fusions of such feelings in the countertransference.

Ruth W. Lidz and Theodore Lidz made some comments on the supervision of the psychotherapy of the schizophrenic patients. Both authors had been supervising advanced residents in long term psychotherapy of schizophrenic patients at Yale University, New Haven for many years. They pointed to the importance and quality of the supervision. Difficulties in communication, sharp and sudden reversals in the patient's attitudes towards the therapist, unexpected regressions into fragment psychosis and the patient's inordinate demands can dishearten the therapist and lead him/her to decide that drugs are the only answer or that he/she may leave the field to those who are more masochistically inclined. Considerable thought and effort must go to supporting the therapist and examining his/her blocks and countertransference problems. Using classical analytic techniques can be detrimental. The therapist should not be aloof and distant and present him/herself as a passive screen against which the patient can react. A schizophrenic patient responds only to a real person who is interested in him/her as an individual. Openness and directness is also the therapist's major projection against being included in a patient's delusional system. Delusions are rarely, if ever, overcome by uncovering their unconscious meaning. The therapist should talk about things that are meaningful to the patient. Information should also be obtained from relatives.

Many patients have a desperate need for closeness and, at the same time, an extreme fear of it, and become panicky over fears of fusion, engulfment and loss of the self. Just when the patient seems to be forming an attachment to the therapist, the patient often flees, sometimes from the treatment, sometimes back into a more regressed condition.

Not all psychiatrists can learn to work effectively with schizophrenic patients. A therapist must have firm boundaries between him/herself and others as well as between fantasy and reality. Supervision can help a person to work with schizophrenic patients, but it cannot make him/her into a person who can do so.

Donald Meltzer: The role of narcissistic organization in the communication difficulties of the schizophrenic.

Psychotic functioning calls for a model for narcissistic organization that is more flexible than Freud's operational description. Meltzer finds a model more concrete in its structural dimensions and more qualitative in its approach to the economic mind in Melanie Klein's work from her paper on

schizoid mechanisms, 1946. This model is basically a view of the unconscious as structured by different infantile parts and their internal objects.

In this paper, Meltzer describes material from the psychoanalytic treatment of three different schizophrenic patients, each case illustrating different problems in communication. All three patients demonstrate the importance of posing the question: "Who is talking? To whom?"

Charles was in treatment more or less continually from age 15 until he entered analysis at 31. He was no longer hallucinated, deluded and catatonic as he had been before. But he was disheveled, avoided eye contact, talked in a muttering and fragmented way. After three years of analysis, he improved socially, took up work, resumed schooling, improved his relations with the family. But when tender feelings and depressive pains began to emerge in the transference situation, he reacted with a hasty retreat. He developed a habit of trying to chase women, who most often were scared of him. He also took pleasure in suspecting the analyst, teachers, bosses and classmates of homosexuality. When the analyst tried to break his refusal of communication, he attacked his words with mockery, punning, caricature, fragmenting and twisting of logic. His schizophrenia was replaced with blatant psychopathic behavior.

Philippa, 16, suffered from a delusional system: a rich man with the same name as the therapist had bought her from her parents to perform a huge research project on schizophrenia to appear in a movie. She developed the habit of commenting on the analyst's every movement: crossing of legs, scratching of an itch and so on. "You cannot seem to control yourself, Dr. Meltzer." As a result of this controlling on the part of the patient, the analyst's interpretative activity became more and more repetitive, and the patient turned to miming instead of talking. Eventually she developed a pattern of staring and blinking. After several months, the analyst interpreted that she was making a photo of the analyst with her eye-camera, in order to recover the object in calm later. The patient answered: "Pictures are just as good as people."

Jonathan, 20, had been in a deep catatonic state for five years and looked like a sad clown or a rag doll, his only verbal responses were almost tic-like. In the fourth year of analysis, his repetitive "dunno, dunno" and "yeah, yeah" had given way to song lines, movie titles and some fragments of life history and culminated in starting to use his own name instead of his alias, "Boris." His absolute despair had given way to hope. Separation reactions became severe.

These cases give us a glimpse of two dimensions in the evolution of speech. The first dimension, verbalization, means that the person is able to introject a speaking - or rather a singing - object, and can repeat it, at first mechanically, later with increasing rhythm and modulation. The second dimension, vocalization, corresponds to the small child's play with sounds as if they are objects in the mouth. That part of the personality which has become schizophrenic is that part which has departed so far into the realm of narcissism that it is beyond the "gravitational" attraction of good objects, and therefore of beauty, truth and goodness. That means that the capacity to communicate states of mind with an object with parental qualities has been attacked.

Containment of the illness, and possibly some degree of recovery, can be hoped for if the avenues of communication are kept open. The investigation of the actual process of communication therefore takes first priority in the consulting room. We must expect, however, that the patient will openly join in ridicule and mocking, gradually to move to the sidelines to watch the struggle between trust and cynicism.

Viljo Rökköläinen: Psychodynamic and interpersonal aspects of the onset of psychosis. Rökköläinen's paper was based on a thorough interviewing with 68 patients, 50 of them psychotic and 18 rediagnosed as borderlines, age 15 to 45, consecutively admitted to the Department of Psychiatry, University of Turku, 1969. Based on this material, he suggests that the reality factor precipitating a psychotic breakdown is qualitatively a narcissistic injury (in Kohut's sense). He also suggests that the onset of the psychosis is a "replica" of the problems of early separation-individual phase (as described by Stierlin).

The onset situation is studied in relation to three important life issues:

1. Separation from the primary family.
2. Progress into a stable position in working life.
3. Stability or change in adult relationships.

A general conclusion was that these patients suffering a psychotic breakdown showed

- narcissistic vulnerability in their early life history
- demands for autonomy in the onset situation
- precipitating adverse life events having a narcissistic significance.

Freud's and Sullivan's two-phase model for the psychotic breakdown can be satisfactorily described in terms of the separation-individuation process.

Failure in early separation-individuation leaves the person in extreme need for protective symbiotic dependence. The first stage in the psychotic process is a failure to achieve symbiotic unions, which leads the person to desperate, omnipotent and non-functional attempts at identity. The final stage is reached when this attempted identity is crushed by unavoidable adaptive tasks of normal life, or by loss of the last vital symbiotic object.

Simo Salonen: On the Technique of the Psychotherapy of Schizophrenia.

Salonen starts with the discussion concerning two competing models for psychosis, both based on Freud's writings. One is what was later called a *conflict model*, advocated by Jacob Arlow and Charles Brenner, the other what is later called a *defect model*, advocated by Nathanael London. From the observation that drive cathexes are never *completely* withdrawn, representations never *completely* absent, he follows Veikko Tähkä in affirming that new structures may emerge during the psychotherapy process. The psychotherapy opens up for a phase-specific interaction process, corresponding in time with the origination of the disorder in early childhood. The therapist is recruited as an object for this process according to the patient's developmental needs, as described by Bryce Boyer and Peter Giovacchini.

Because of the massive destruction of cathected representations, drive energies are seeking their discharge on an almost physiological level, an observation first made by Edith Jacobson. This fact makes the therapist's capacity of "holding function" (Winnicott) all the more important.

Salonen describes two cases of psychoanalytic psychotherapy with psychotic patients, where a holding and containing analytic attitude has prevailed. Separation experiences and separation anxieties have been interpreted and worked through. Gaps in the patients' narcissistic protective organization (narcissism as Kohut's defines) have been repaired and formerly de-cathected representations have been re-cathected and vitalized.

John S. Strauss and Marc A. Frader:

Justifying intensive psychotherapy for schizophrenia in a community treatment center.

The authors stated that serious criticism had been raised against the use of intensive psychotherapy for treating schizophrenics with the increasing desire and pressure to provide psychiatric treatment for all who need it.

Such treatment may serve no useful purpose and even if it did, it would not be feasible because of the scarcity of treatment resources. They also said that the justification of such treatment was complicated further by a dualism basic to psychiatry. On the one hand, the individual, his or her humanity and personal growth are considered as central. On the other hand, assessment, classification and treatment techniques focusing on large numbers of patients are needed to care for all those needing help and to increase our knowledge through controlled studies. The authors asked: Given these problems, can intensive psychotherapy for schizophrenics being treated in a community treatment center be justified? To evaluate this, the authors examined four issues: (1) Possible advantages of psychotherapy as a treatment modality for schizophrenics; (2) Limitations of psychotherapy resources available in a community treatment center; (3) Increasing the number of therapists and maximizing the effectiveness of therapeutic resources by modifying techniques, and (4) Developing methods for allocating psychotherapy resources.

The authors discussed these issues extensively and stated, among other things:

(1) The personal meaning and interpersonal implications of symptoms and disordered behavior can be dealt with in psychotherapy. Without such intervention, the messages these symptoms have regarding adjustment and growth problems are lost forever. Individual psychotherapy can have an important role in helping the individual to deal with his/her psychosis, difficulties in relating to others and with possible precipitants for the psychosis, including difficult family relationships or other stresses. If intensive psychotherapy does have useful functions for treatment, training and advancing our knowledge, the question is whether such a treatment is logistically feasible in a community treatment center.

(2) Information was collected from two communities for the report presented to provide a more concrete estimate of the severity of resource limitation. If these two communities were more staffed with potential psychotherapists than most (in the USA), how is it possible to consider individual psychotherapy as a practical approach to the treatment of schizophrenia in such settings?

(3) Because of the large populations of schizophrenic patients who come to community mental health centers for treatment, those facilities should also

be used as training centers for psychiatric residents and other mental health professionals who wish to learn about psychotherapy with schizophrenics. An important approach is to maximize the effectiveness of the limited psychotherapy time available, for example, exploration of the patient-therapist relationship during treatment and helping schizophrenic individuals cope with and adapt to everyday social and interpersonal events; promote the patient's continuing existence in society and minimize the need for hospitalization and, if hospitalization cannot be avoided, try to develop as much liaison with the inpatient ward as possible.

(4) The crucial issue in considering allocation of scarce treatment resources is what level of functioning and happiness can be expected in a person with a given treatment in contrast to how he will be if the treatment is not provided. The harsh reality of limited resources requires consideration of how to allocate these resources to provide the most benefit - "triage" may be needed. Certain key principles and procedures are necessary to develop a focus and specific goal of effective triage: (a) to use psychotherapy resources for those patients with whom these resources would make the greatest difference between a full and successful life and a vegetative or miserable one; (b) clearly defining and evaluating reliably dimensions of outcome function covering several aspects of living: at least symptoms, interpersonal function, and work function; (c) improved systems for classifying patients: systems of multi-axial diagnosis using several "axes" or dimensions on which to evaluate patients, for example: symptom picture, course of disorder, premorbid social function, premorbid work function, and the nature of any precipitating events related to the onset of his/her symptoms.

In the conclusion, the authors said: Through specifically defined research, we might be able to provide considerable help to the therapists in the community setting who need to use their resources as efficiently as possible.

The Arezzo Group¹: Schizophrenia and psychotherapy in the light of the class struggle and democratic psychiatry. Italy became a nation as late as 1861. The

¹ This paper was written with the active participation of Vieri Marzi, Agostino Piralla and Paolo Tranchina.

economic development and accompanying social transformation took place slowly and in a period when England, France and the United States were modern, industrialized societies. The Catholic Church was more influential than in most other countries, as an unconditionally anti-liberal factor. Liberal democratic institutions were not well developed, and the mentality in the ruling classes were still pre-modern when Mussolini came to power in 1922, a fascist dictatorship that lasted until 1944. During this period, a strongly repressive atmosphere prevailed in all the institutions dealing with marginalized people, like prisons, mental hospitals, reform schools, orphanages, homes for the elderly and so on.

After World War II, the Italian society was modernized economically with US economic investments and aid. The labor unions and political parties voicing the interests of the working classes continued to be repressed. The communist party had been banned during the Mussolini era and had grown into a formidable political force during the war. During the period called the Cold War, Italy more than other Western countries became the battleground between rightist and leftist forces.

During the 1960's, more and more people saw the need for democratic reforms in both national and regional institutions, including psychiatric hospitals. Franco Basaglia and his coworkers in Gorizia had started to develop ideas for mental health care reforms from 1961, and his book "*L'istituzione negata*" (1968) became a manifesto for the movement called *Psichiatria democratica*, which was founded in 1975. Centers for this movement were Trieste, Ferrara, Reggio Emilia and Arezzo in Tuscany.² The ideology behind the psychiatric reform was from the therapeutic community model (Maxwell Jones) and psychotherapy principles from Sullivan, Fromm-Reichmann, Benedetti, Müller and others. The working methods were group meetings, home visits, network meetings and all other activities known from the therapeutic community, but applied to the local setting and neighborhood, town or city.

² A law requiring the closing down of the old-type mental hospitals in all Italy was passed in 1978.

II Family studies: implications for treatment

Yrjo O. Alanen presented some of the results and experiences he and his co-workers made through a research project with 30 odd schizophrenic patients and their parents in Helsinki and Turku between 1966 and 1972, including a follow-up 1972/73: *On background and goals in the family therapy of young schizophrenic patients and their parents.*

Psychodynamically oriented conjoint sessions with the patient and his/her parents formed the predominant therapeutic approach. In 17 cases, the family therapy was combined with the patient's individual psychotherapy following the family therapy, particularly in cases when the patient had disengaged him/herself sufficiently from his/her family and interests and object relations had become outside the family.

One of the most important indications for family therapy was mutual dependency problems, and pathological emotional ties between parents and child. They often found a striking lack of empathy for the child in the parents. They unconsciously "utilized" the child for their own narcissistic purposes. This explained why changes in and recovery of the child could constitute a threat to the parent's own psychic equilibrium. Manifestations of aggression were more or less forbidden in many of these families. In favorable cases, the patients experienced the improvement of their parent's mutual relationships as a factor enhancing their own integration and bringing them relief.

Emphasis was on the treatment of the patient's parents and another on the treatment of the patient him/herself. The common goal was to relieve the disturbances of the family environment and to weaken the mutual dependency ties, to promote the patient's individuation and psychological separation from the family and, at the same time, help the parents endure this. It was highly important for the parents to experience the therapist as an empathic and support-giving person so that they could transfer their own dependency needs to him/her. One of the therapist's central tasks was to "translate" the patient's communication into a form that would be easier to understand.

In the follow-up study, four patients were completely free from psychotic features and two had also benefited very considerably from the family therapy. Eleven had other positive experiences. Alanen concluded that the

duration of the family therapy ought to be two to four years and one session a week in order to be adequate.

Stephen Fleck presented: A general system view of families of schizophrenics. He used the general system approach as a framework to study and assess families and to bring some measure of order into the chaotic world of family pathology. Like any other open system, a family can be examined and evaluated in terms of its central functions and goals, leadership, boundary integrity and management among system components and between the group as a whole and the outside, managerial links and affective bondage within it, effectiveness and relevancy of communication inside the system and between it and the outside world. The human family is a special group because of biosocial and cultural givens, which require that the family nurtures and humanizes the young by teaching them not only about themselves and how to live within a family but also about the mores, cultural values and instrumentalities of the society. The family is the keystone of society and must fulfill the aforementioned system functions. The family must also introduce children into society in school and in peer relations and familiarize them with the tools and values of their society. If it malfunctions, this may burden and handicap offspring severely, particularly so in the process of emancipation from the family, to become a full-fledged adult member in society.

Fleck demonstrates how failures in several of these areas are typical for families with schizophrenic offspring in three clinical illustrations. The examples showed the parents as severely disturbed, rendering the formation of an effective parental coalition and leadership impossible. In the parent-patient triads, they saw global task deficiencies in all evolutionary phases. There were boundary violations, inconstant emotionally bonds, probably incestuous and anxiety laden. Communication was ineffective, bizarre and fragmented. The clinical data so far suggest that the number of severity of system defects may determine pathological outcomes rather than any particular defect in and of itself.

Fleck concluded that schizophrenia is a deficiency disease of family functioning and task performance.

M. Selvini Palazoli, L. Boscolo, G. Cecchin and G. Prata, working in a private outpatient center in Milan, presented what was probably a provoking new

model for many of the participants: *Therapy of the family in schizophrenic transaction: paradox and counterparadox*. One heterosexual couple of therapists worked with the family, one other couple remained behind a one-way mirror in an observation room. They could intervene in the session at any time to call one of the therapists into the observation room in order to make observations and give advice. The family was always informed of their work method. After the interview with the family, the team meets together to discuss the possible conclusion of the session and then the two active therapists rejoin the family and make the final intervention, which is always crystallized to a few sentences.

Inspired by the works of Bateson, Haley and Watzlawik, the team learned to think in an entirely new way, to conceive reality not in a linear but rather in a circular manner, where the concept of *function* is central. They abandoned the verb *to be* and substituted it with the verb *to show*, which enabled them to understand the interplay in the family game. This interplay in the family of schizophrenic transaction is based on the prohibition or taboo of defining the relation. Paradoxical communication is an outstanding tool in the service of this taboo. Schizophrenia becomes a crazy collective game with demanding and relentless rules, which impose moves and countermoves upon all the members of the family in the service of an endless game.

The experiences of this team had constantly demonstrated that a counterparadox, which strikes home, could trigger a great change in the system. The team wanted to go beyond the barrier of rational dichotomies as reasonable - unreasonable, normal - abnormal, real - unreal, bringing the game to the absurd, until they reached the point in which the continuation of the game is rendered impossible. Since the family always tries to disqualify the therapists, the only possible disqualification left to them is the change of the game. Thus, from session to session, the crazy game brakes down, and the crazy behaviors lose their logic.

1. The basic contribution of the team was:
2. The positive connotation: In all observed behaviors, the therapists declared themselves to be allied to the homeostatic ideal of the family.
3. The systemic paradoxical prescription to the entire family.
4. The concept of variable time in family therapy.

Because the paradoxical intervention needs a certain time span for the reorganization of the system, they found that the most opportune time span

between the sessions was one month, and not beyond a total number of 20 sessions (one to two years of therapy).

Helm Stierlin, in his presentation: *Perspectives on the individual and family therapy of schizophrenic patients*, started with the paradoxical clinical experiences from different therapists: A first proposition stating that mere “individual therapy of schizophrenic patients does work,” and a second one stating that “it does not work.” Evidence of the first is published by a number of pioneer therapists. Other clinical evidence, no less impressive, appears to challenge this notion. These researchers conceptualized the homeostatic and system forces, keeping the schizophrenic locked into his family ghetto. Double bind, pseudo-mutuality and pseudo-hostility, rubber fence, blurring of intergenerational and other boundaries, consensus sensitivity, undifferentiated family ego mass, inter-subjective fusion and cognitive and affective binding, capture many schizophrenic patients maddingly tight with his/her family. These forces can only be dealt with by including the patient’s family in the treatment.

In a number of cases, however, a family’s involvement becomes unnecessary because there is no longer a meaningful involvement between the parents and child generations. This may occur under *the expelling mode*, where the patient had been pushed out prematurely, left to his/her own devices. But even in some of these families, there are hidden ties that connect as well as disconnect many parents and their hospitalized offspring. They came to be perceived as “ill, mad, beyond human influence or concern.” He/she was condemned to a living death in a mental hospital. But this “dead” patient retains the power to fill the parents’ lives with never ending terror, concern and guilt.

An individual approach that focuses on a sick patient may free parents from blame and guilt of ruining their child’s life. In other instances, while supporting an individual psychotherapy, parents may feel they can do something for the child after having suffered long periods of helplessness and despair.

Stierlin describes the *id-binding* mode where the parents manipulate and exploit the child’s dependency needs, for example by affording massive, regressive gratification, sexually over-stimulating or frustrating them. In the *ego-binding mode*, the parents intrusively substitute their own for the child’s ego and these families are characterized by an undifferentiated ego -mass,

a consensus sensitivity, a cognitive chaos and their penchant to disqualify and blur anything and everything. In *super-ego binding*, they foster a deep loyalty, which causes the child to reel under brake-away guilt, should he/she ever in thought or action, try to individuate or separate. The patients very likely undo any therapeutic gain they made in individual therapy and thus sabotage themselves, act out and signal to their parents and therapists that psychotherapy is useless for them. These families should be included in the treatment as soon as possible. Some patients are *delegates of their parent*, they are sent out and entrusted with impossible missions, i.e. to embody and actualize a parent's grandiose, unfulfilled ego-ideal, or serve his/her parent's self-observation by embodying and enacting their own disowned madness.

Research projects

John G. Gunderson: Recent research on psychosocial treatments for schizophrenia.

John Gunderson's presentation reviewed recent research, which re-examines the effects of psychosocial treatments and their interactions with drugs. He based his review on the four basic types of controlled research design which are utilized to evaluate the effects of treatment in schizophrenia and also other studies relevant to the evaluation of psychosocial treatments: those where one treatment program is compared with another without efforts to control specific drug or psychosocial treatments within the program and those studies which attempt to isolate the therapeutic ingredients within a given psychosocial treatment. He reviewed studies that tried to shed light on the following issues: psychosocial therapies and drugs; drug non-responders; are drugs contraindicated?; milieu therapy; group therapy; family therapy; and individual psychotherapy.

Implications for research: Since the effectiveness of drugs seems to depend both on the sample of patients and the psychosocial treatment context, researchers must redouble their effort to make these variables well-defined and whenever possible controlled. The impact of milieu therapy seems sufficiently large that studies should not consider this a "no treatment" control. There is clear need for better refined and more reliable instruments and usage of common assessment instruments - for example: subtyping of

patients, subgroups of non-responders to drug treatment, instruments characterizing different treatments (nature, attitudes and goals of therapy), outcome measures (with some specificity for the type of treatment being evaluated), the need for measurements of interpersonal closeness and subjective comfort - in addition to widely accepted symptom measures. Longer follow-up is required. There is the need to assess the effect which the researcher's own motives and expectations have upon the results.

Implications for clinical practice: The question of whether psychosocial treatment of schizophrenia adds anything to drugs has been uniformly and convincingly answered in the affirmative. There is certainly little justification for the exclusive reliance on drugs as the "single most important treatment for schizophrenia." If anything, milieu therapy would seem most able to justify this claim. The impact of psychosocial treatments on chronic patients is perhaps more surprising than the results for the acute patients. Several studies suggest that relatively non-intensive and inexpensive interpersonal therapies can significantly add to the effectiveness of drugs in aftercare. Other studies are needed to test whether more expensive and more intensive therapy would further improve outcome results. The results also suggest that an enthusiastic and highly motivated staff is more important than the specific treatment models around which the therapeutic milieu is organized. The exception may be the use of a behavioral modification model in the treatment of highly chronic schizophrenics.

These implications provide a convincing rejoinder to recent efforts to write off the importance of human intervention in the treatment of schizophrenia for economic, ethical or ideological reasons.

Edgar Heim and Einar Johnsen with co-workers presented an explorative study from the psychiatric clinic "Schlössli" in Oetwill, Zurich with 400 beds, developed through different phases of milieu-therapy, therapeutic communities both in the different wards and in the hospital as a whole. One goal was to find certain indications regarding the process and context of the milieu therapy in Schlössli. A second goal was to clarify the position of the schizophrenic patient within the therapeutic community: *Application of the principles of the therapeutic community with the participation of schizophrenics.*

Heim first presented the method and the principles they planned to follow in the study:

1. Retrospective, historical descriptions of the hospital development.
2. Sociometric procedures registering certain interactional processes by means of existing scales.
3. Explorative interviews with participants in a given social field.
4. Action research, which, however, was difficult to implement in a psychiatric institution.
5. Participant observation, which they found particularly useful for determining the most important forms of interaction and group processes in a therapeutic community. The observations must, however, ensue systematically. These observers were assigned to three different wards, each observer working in each ward for one week.

Heim then mentioned the main principles of the therapeutic community: Advance adequate communication. Create opportunities for social learning. Advance social and group processes. Reduce hierarchical structures in order to advance sharing responsibilities.

The general impression of the schizophrenic patients showed no homogeneity. However, they found two different groups of these patients. One group, (A) = active, showed more than average involvement in the events reported in both the ward meetings and the group therapies. They were actively represented in decision making during the ward meetings, however, in the group meetings, their affective presence was hardly felt at all. This group of schizophrenics is marked by a communicative, active, emotionally highly-strung and vulnerable nature, while at the same time being endowed with an excessive sense of justice. They seemed to derive considerable benefit from the principles of the therapeutic community.

In contrast with this group, they found another group of schizophrenics, (P) = passive, usually sitting around apathetically, quiet and withdrawn. This group of schizophrenics are lost in the group processes and in the active programs of the ward. They were easily overtaxed by the demands made on them in the culture of a therapeutic community. But even this group showed some profits. The medication could be reduced, isolation of a patient was only rarely called for, and clearly structured activities, reality oriented action and intensification of external contacts was steadily increasing.

As conclusion, Heim clearly stated that particularly schizophrenics respond to different milieu concepts. The future milieu therapy must therefore aim at differentiating relations with patients, particularly with schizophrenics. These patients need a therapeutic treatment, which includes the level of behavior (e.g. symptom healing by means of medication), social interaction (by means of milieu therapy) and insight (by means of psychotherapy).

Endre Ugelstad: Psychosocial treatment alternatives for long-stay schizophrenic patients

Ugelstad, Norwegian pioneer in the psychotherapeutic approach to psychotic patients, presented the results of treatment outcome study performed at Gaustad Hospital, Norway in the period 1972-74. Thirty male in-patients with schizophrenia, age 25-45 (average 33) with a long history of hospitalization (average 6 years +) were distributed into four different treatment programs:

- extramural rehabilitation situation
- intensive treatment in a small milieu therapy ward
- intensive treatment individual psychotherapy while staying in a traditional ward
- treatment as usual in active milieu treatment ward.

Preliminary results showed that a majority of the patients in the two intensive treatment groups had achieved considerable improvement, compared to the patients in the two other groups (extramural rehabilitation and intramural treatment as usual). Among the six patients who made up the intensive milieu treatment group, three managed to start and keep work outside the hospital during the 15 month program, and two (one in the working subgroup) managed to move out of the hospital and live outside. Only two patients were unchanged. Among the six patients who made up the intensive individual therapy group, three, all with paranoid symptomatology, obtained a significant degree of insight in their family conflict history leading up to the breakdown. Two of these were discharged during the treatment period. A fourth patient resumed schooling while still living in the hospital. A fifth one, a very withdrawn man, committed suicide unexpectedly during the treatment period while the sixth, a young hebephrenic man, remained unchanged.

Ugelstad's study was the first in a series of intensive psychosocial treatment programs both in Gaustad Hospital and in other Norwegian mental hospitals during the 1970's and 1980's. Many of these subsequent programs were studied and evaluated greatly under the umbrella project called Nordic Investigation of Psychotherapy for New Schizophrenic Patients (NIP), which consisted of groups led by Endre Ugelstad, Norway, Rolf Sjöström, Sweden, Yrjö Alanen and Klaus Lehtinen, Finland and Bent Rosenbaum, Denmark.

Lyman C. Wynne, Margaret Thaler Singer, and Margaret L. Toohey: Communication of the adoptive parents of schizophrenics. This report brought two approaches together for the first time that heretofore only had been applied separately in research on schizophrenia: (1) the study of the adoptive parents of schizophrenics and (2) the study of deviant parental communication. Ten families with index adoptive schizophrenic offspring were studied. Two comparison groups were selected to match the adoptive schizophrenic cases as closely as possible: (1) families with schizophrenic offspring reared by their biological parents and (2) families with adoptive non-schizophrenics. All three groups of parents were interviewed with a semi-structured interview schedule covered topics intended to evaluate each parent's psychological functioning and psychiatric status. Conjoint interviews with each pair of parents elicited a current assessment and developmental history of the offspring. The parents were each given a battery of psychological tests (Rorschach, TAT, MMPI, WAIS, and others). The Rorschachs were tape-recorded and transcribed verbatim. Analysis and scoring of the Rorschach typescripts were done under scrupulously blind conditions. The paper presented the results of assessing these blind assessments with their manual for scoring communication deviances. The findings supported *both* a genetic hypothesis *and* a psychosocial hypothesis. The authors stated that the results were complementary rather than contradictory. Parental psychopathology and parental communication deviances are derived from different but compatible conceptual frames of reference: (a) the concept of direct, individual genetic transmission and (b) the concept of multidirectional psychosocial influences manifest in communication patterns that have unfolded overtime. Their formulation of the family as a transactional social system incorporates and builds upon genetic and biologic characteristics and the personality features of family members, which "fit" together - or fail to do so, during the multiple tasks of individual and family development. The findings also strongly suggested that some characteristics of late adolescent and young adult schizophrenics are linked by non-genetic psychosocial processes to the communication patterns of rearing parents.

Most psychiatric researchers assume that behavioral traits and symptoms, including those called schizophrenic, are the results of interaction between genes and environment, rather than either acting independently. This report represented a collaborative effort to tap both genetic and psychosocial processes in the same strategically selected sample of adoptive subjects.

The symposium ended with a panel discussion: *Essential factors and future prospects in the relation between schizophrenic persons and their psychotherapists.*

Otto Allan Will pointed to three essential problem areas in schizophrenic patients: attachment, regression and separation. But these are problems of human living, which everybody has to deal with. *David Rubinstein* agreed that the problem of psychotherapy of schizophrenics is probably closely ingrained with the whole problem of human living. He also mentioned the social and political aspects of the care of patients who are called schizophrenic. *Christian Müller* mentioned that our knowledge has grown and that new dimensions like the family dynamics entered the scene. The ideal model may be the combination of an intensive psychoanalytical oriented individual psychotherapy and the organization of the setting, the contact to the family, to walk with the family. *Gaetano Benedetti's* message underlined the efforts of the therapist to separate him/herself from the aggressive phantasms of the patient and to offer the patient a good object, which merges with gratifying phantasies but, in spite of its relatedness or identification with the internal phantasm, never disrupts the patient's integrity. If the patient succeeds in perceiving the therapist as a good object, he becomes ready to discover the good object within him/herself. Again and again, he found that the readiness of the psychotherapist to speak to the patient within his/her own world, through his/her images, is a first step towards reaching him/her. *Clarence Schulz* said that psychotherapists will gradually be working with newer concepts and newer contributions and he mentioned the valuable contributions from Otto Kernberg and Heinz Kohut and their concepts. *Helm Stierlin* stated that this had been a most comforting conference of the friendliness of finding oneself in the same boat in this difficult work. As a conclusion of the Symposium David Rubinstein experienced that this conference had a feeling of warmth, attachment, necessity to exchange views, to fertilize each other and then let go, so we then can come back again.

After the termination of the Symposium, nine of the participants conducted seminars in various parts of Norway, arranged in cooperation with the Psychotherapy Committee of the Norwegian Psychiatric Association: Gaetano Benedetti in Stavanger, Helm Stierlin in Bergen, John S. Strauss in Tromsø, Beatriz Foster at Blakstad Hospital in Asker, Theodore Lidz in Hamar, Otto Allan Will in Trondheim and Mara Palazolli Selvini had a special seminar on family therapy in Oslo.

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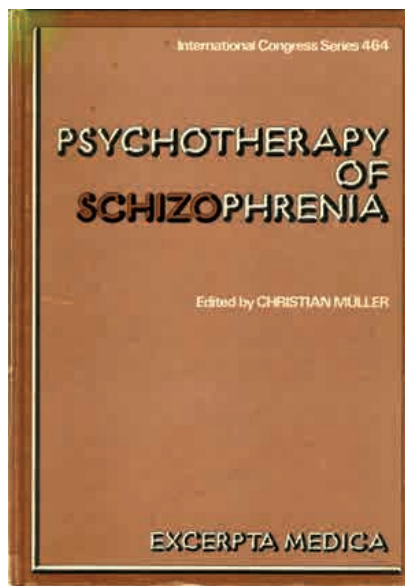
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Book of Lausanne Symposium.
1978

CHAPT. 6 PHOTOGRAPHS



From left to right Helm Stierlin, Harold Searles and Lyman C. Wynne in Lausanne Symposium 1978



Christian Müller and Endre Ugelstad, Lausanne 1978

6. The VIth ISPS Symposium In Cery/Lausanne, Switzerland, September 28-30, 1978

Christian Müller

If I call to mind the course of this symposium and go through the list of participants and publications, what results from it is the recognition that this symposium, like those of 1956 and 1964 which likewise took place in Lausanne, is closely connected not only with the history of the Psychiatric Clinic in Lausanne but also with the history of Swiss psychiatry as a whole.

In 1956, I went forward almost daringly, or so it now seems, afterwards. As a young, thirty-five year old senior physician, I had the cheek to write to the leading therapists of the era. Those who came included Mitscherlich, Binswanger, Blum, Racamier, and others. The situation for the mentally ill in that hospital at the time was still rather catastrophic. Although it was indeed a clinic affiliated with the university, it was at the same time the regional hospital for a canton with around half a million inhabitants. There were overfilled waiting rooms and insufficient hygienic facilities, adequate occupational possibilities were lacking, there were meager provisions, underpaid doctors and nurses. I wanted to take action against this desperate insufficiency. That is why I was able to convince my friend, Benedetti, that together, we could take a bold step. That was already described in previous chapters.

In 1978, however, the situation was completely different. Psychoanalysis had gained a foothold in the medical world of Lausanne; we were no longer fighting single-handedly, rather, we formed an entire group. As can be deduced from the program of 1978, success had once again been achieved in winning over top-quality lecturers, some of whom were the same that we had already brought together in 1956, 1959, and 1964.

Once again, I was able to count on the self-sacrificing help of my secretaries, especially Ms. *Marianne Junod*. And we also had to struggle with the same

problem that Alanen describes for the Fourth Symposium in 1971 in Turku, Finland, namely, there were numerous requests for the possibility of participating, requests that we had to reject because of reasons of space, which often brought harsh criticism down upon us.

In the more than twenty years since 1956, the face of the Lausanne clinic had changed dramatically. Although the sexes continued to be separated, the new building with its comfortable triple rooms, recreation rooms, the highly developed occupational studio, the family care, the systematic training of the assistants in analytic psychotherapy, and so on, all of this contributed to our not only being able to offer our guests a comfortable conference setting but also being able to point to that which had been achieved.

If the list of lecturers is scrutinized, then what is surprisingly revealed is that in spite of the location – namely, Lausanne – the majority of the speakers came from the USA or Scandinavia. Thanks to the aforementioned renovations and new buildings in the University Psychiatric Clinic in Lausanne, we could distribute the events well, alternating between main lectures and group events.

I will never forget how elegantly *Endre Ugelstad*, who sadly passed away early on, presided over the first session. *Harold F. Searles*, who had caused a sensation with his uncompromising suggestions for long-term analytical psychotherapies with schizophrenics, was there and spoke on identity. *Thomas Freeman*, one of the few European psychoanalysts who had spent his entire life in psychiatric institutions, discussed clinical and theoretical considerations in detail. If one looks over the lectures which were held in the various language groups, then names surface again and again that carry international significance even today: *Raoul Schindler*, *Paul Matussek*, *Martti Siirala*, *Yrjö Alanen*. That which Alanen reported for the Symposium that he organized in 1971 in Turku also held true for us in 1978, namely, the growing interest in family therapy interventions and system theory considerations in the nature of schizophrenia. What has also particularly remained in my memory is the wonderful lecture by *P. C. Racamier* on ambivalence and paradoxicality in the treatment of schizophrenics. He, too, is one of the psychoanalysts who spent a lifetime in the institution and in the analytical treatment of schizophrenics.

The family therapy approach was represented above all by *Helm Stierlin* and *Lyman C. Wynne*. They both spoke in English. In the meantime, at my clinic

in Lausanne, the group had consolidated around *Luc Kaufmann*, and out of the first timid attempts for the introduction of family therapy at that time, the institute for family therapy in Lausanne later came into existence and was directed by Kaufmann. Mention should also be made of other prominent names: *Stephen Fleck*, *Theodore Lidz*, and *Loren S. Mosher*, the latter of whom spoke about his Soteria project. It is generally recognized that he triggered a worldwide echo, and it should also be noted here that *Luc Ciompi* later built up a similar therapeutic center in Bern.

On the evening of the first day, we attempted to have as many colleagues from abroad invited into the Lausanne psychiatric circles, which apparently was quite successful. On Friday evening, we set out for Romainmôtier, a town with a fabulously beautiful Romanesque church and a priory where we dined.

I now think that the course of the Symposium was satisfying, although I would like to draw one distinction here: our First Symposium in 1956 was characterized by a pioneer-like approach, a daring endeavor, while at the Sixth International Symposium in Lausanne in 1978, a certain routine was already present. It was no longer necessary to unfurl a new flag or, as the venerable *Ludwig Binswanger* had encouragingly called for us to do in 1956, to bring about a new psychiatric revolution; rather, it was necessary to consolidate and strengthen that which existed, that which was known, and that which could be exchanged.

In retrospect, it also seems remarkable to me that with all of these Symposia including the one in 1978, they were not about lectures and publications with regard to career possibilities while keeping one eye on impact factors. They were not about the handing out of university chairs, but rather all about a genuine, pioneering matter of concern to move the psychodynamic view of schizophrenia and its treatment into the foreground. What also still strikes me at this juncture is the fact that out of all of the participants at that time, no one to my knowledge has renounced the psychodynamic view and categorically migrated over into the camp of the pharmacotherapists. And of course there was also reason for fanaticism; during those years, we psychoanalysts never presented the view that a schizophrenic could not also be comforted by medicines. Even my patient Pierre, about whom I reported in 1956 in *Psyche* and who was one of the people for whose sake I brought these Symposia into being, indeed even he received neuroleptics.

The difference between our first two Symposia in Lausanne and that of 1978 also becomes clear if one takes the program of 1978 in hand. It was refined, beautifully printed, it was a stark contrast to the humble, rather helpless typewritten text that we sent out into the psychiatric world in 1956.

The fact, though, that the Symposium for the Psychotherapy of Schizophrenia would turn into a worldwide organization as it appears today was something that Benedetti and I could never have dreamed of at that time. We were already very pleased at the simple idea that the University of Lausanne supported our efforts, that the hospital made the facilities available, that the hospital kitchen provided us with lunch, and that all of the medical and non-medical employees of the clinic joined in with enthusiasm.

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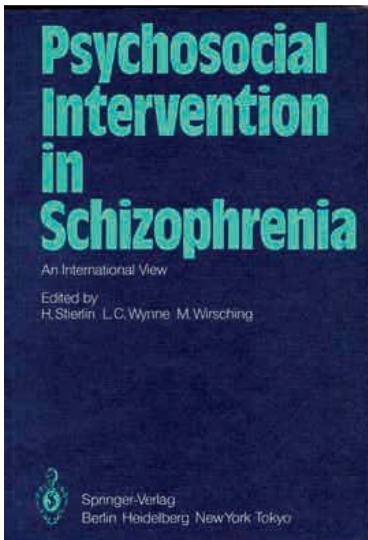
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CHAPT. 7 PHOTOGRAPHS



*Book of ISPS VII Heidelberg
Symposium 1981*



*Helm Stierlin and his
wife Satuila*

7. The VIIth ISPS Symposium In Heidelberg, Germany in 30.9-2.10 1981

Helm Stierlin

A quarter of a century has gone by since the symposium took place. That is a long time when it comes to remembering things, so that in the following, I had to rely on my fading memory, on my diary and on the papers presented in the congress volume: "Psychosocial Interventions in Schizophrenia," edited by *Helm Stierlin*, *Lyman C. Wynne*, and *Michael Wirsching* in 1983 (Springer Verlag, Berlin-Heidelberg).

Approximately 250 colleagues from Europe and the United States participated in the symposium organized by my team mates at the Abteilung für psychoanalytische Grundlagenforschung und Familientherapie at Heidelberg University. Their enthusiasm infected both many others and me and I continue to be full of appreciation for all they did.

I vividly remember the introductory public address by *Christian Müller* with the title "Die Begegnung mit dem Schizophrenen und seiner Familie" (The Encounter with the Schizophrenic and his Family) whose pleasant, almost poetic flow and philosophical tone were interrupted by the shouting of a schizophrenic in the audience, apparently driven to make his own contribution to the symposium. The lecture took place in the Alte Aula of Heidelberg University, a stately lecture hall in which such distinguished scientists and thinkers as Georg Wilhelm Friedrich Hegel, Max Weber and Karl Jaspers had captivated their audiences in previous times.

In our introduction to the earlier mentioned congress volume, we three editors spoke of "a salutary confusion" regarding the etiology and therapy of schizophrenia as the possible most striking characteristic of the symposium. And it seems to me after rereading his text that Christian Müller's opening lecture, albeit in itself not confusing, highlighted this characteristic. He implicitly or explicitly referred to the often confusing diversity of experiences, of basic assumptions, of treatment approaches and treatment experiences that were presented at the symposium. This diversity made me,

in this brief chapter, have to repeatedly shift my observing lenses, to be selective, to reduce complexity and yet to try to convey what I considered to be essential.

What this task implied was highlighted by one term that Christian Müller repeatedly used in his introductory speech: the term, “the schizophrenic.” This is because it could suggest that there is a consensus among researchers and therapists as to what the schizophrenic is and what happens in his/her inner life. But that is not the case as the symposium so strikingly showed. To be sure, we now have several diagnostic manuals to guide us in making the schizophrenia diagnosis. However, the label “schizophrenia” continues to cover a wide variety of clinical manifestations, of inner experiences, of possible life courses, of prospects for complete or incomplete recovery and hence also for special treatments that may be indicated. So, with the above in mind, let me first turn to *the topic of individual therapies* as these were presented at the symposium.

One of the presentations of these therapies stands out because it was enriched by impressive material from a patient: the therapy presented by *Gaetano Benedetti*.

Benedetti’s lecture was titled “Possibilities and Limits of Individual Psychotherapy of Schizophrenic Patients.” In order to illuminate such possibilities and limits, he reported on the first three years of his treatment of a patient who showed a remarkable ability to express herself in verses and in painting done by herself. Benedetti started his lecture by reciting a lengthy poem in which she described the inner hell she had been experiencing. The last lines of the poem read as follows:

Fear is hanging
Like a giant drop
Encompassing the world
And the monstrous depths
Of nothingness
Into which I am falling
On the way down
Accompanied by multicolored rage
And the loss of solidity
And the decay into undefined gravel.
Always and again this hated presence

While the rage
Like a transparent bomb
Ticks on.

This rage, hypostatized as a transparent bomb, was continuously unleashed against the therapist who “attempted to take this embittered and malignant violence into himself with benevolent calm, which sprang from his connection with the inexpressible human substance of the psychotic person.” Benedetti characterized his work as a “dualization which expresses a process that makes psychotherapy possible, but also transcends it dialectically,” a process highlighting a drama during which the therapist “has stepped into the contradiction of opposites, for example, the contradiction between objective countertransference and subjective identification with the patient’s suffering.” This drama was also revealed in strikingly colorful paintings done by the patient during various phases of her therapy and reproduced in the congress volume. However, at the end of this case presentation, Benedetti warned us that several factors might mitigate against the feasibility of this kind of individual therapy such as lack of motivation on the part of the patient and possibly also the attitudes of family members who, instead of supporting such individual therapy, might sabotage it overtly or covertly.

John Kafka and *Clarence Schulz* - two colleagues with whom I had become friends during my years at the staff of the Chestnut Lodge Sanatorium in Rockville, MD - belonged to those participants who also reported or commented on their individual psychotherapeutic work with schizophrenic patients. This work was guided by a psychoanalytic model that required working through the patient’s deep seated inner conflicts and traumas in a lengthy process of transference and countertransference. At this Lodge, this process was thought to require typically several years. Frieda Fromm-Reichmann, Otto Will and Harold Searles, all of them associated with the Lodge, were some of the pioneers in applying psychoanalytic principles to the psychotherapy of schizophrenia and I, at the symposium, again and again believed I could feel their presence.

The work which *Paul Matussek* and his co-workers presented at the symposium also largely unfolded in the framework of classical psychoanalytic theory. Thus, it could be seen as the German equivalent of the work carried out at Chestnut Lodge. Matussek was then heading the Research Institute for Psychopathology and Psychotherapy of the German

Max Planck Society. By the time the symposium took place, he and his 18 co-workers had been treating nearly 100 schizophrenics with individual psychotherapy.

Matussek emphasized the changes this therapy had undergone since its beginnings in the fifties. At that earlier time pioneering therapists such as Sechehaye and Rosen had tended to foster a patient's regressive gratification by, for example, feeding him or her with apples. Such an approach now seemed ridiculous to Matussek. Rather, he stressed the importance of a stably established transference "In view of the present state of our analysis," he stated, "I can already say this much: the success of the psychotherapy of psychoses - independently of their duration and symptoms - depends, above all, on the successful establishment of transference."

However, there were also voices heard at the symposium which, in one way or the other, were apt to cast doubt on psychoanalysis as the royal road to the treatment of psychotic patients. One such voice was that of *Robert Cancro* who titled his presentation "Some Preliminary Thoughts on the Psychotherapy of Schizophrenics." Even though Cancro paid tribute to pioneers in the field such as Federn, Sechehaye, Schwing, Fromm-Reichmann, Sullivan and Hill, he pointed to factors which, in the treatment of schizophrenic patients, could cause us to doubt the leading role of individual psychotherapy in general and of psychoanalysis in particular. "Psychotherapeutic approaches to schizophrenic patients," he stated, "differ greatly and this variability contributes significantly to the methodologic problems inherent in their evaluation. The search for the common factors in the different but successful psychotherapies is essential for adequate evaluation research." Accordingly, he reminded us: "The therapist must have an excellent tolerance of uncertainty if not an actual ability to enjoy it" and "If tolerance of uncertainty is important, tolerance of error is essential."

Uncertainty as to the feasibility and efficacy of a long lasting individual psychoanalytically-oriented psychotherapy of schizophrenic patients could also be gleaned from the comments of other contributors. As I remember it, *Theodore Lidz* and *Thomas McGlashan* belonged to this group. They referred in particular to the individual psychotherapies conducted at the Lodge. I remember Lidz questioning the value of a hospital setting which fostered the patients' regressive gratification, kept them (more or less) away from their families and made it difficult for them to return to, or start anew, an active professional life. McGlashan, a staff member at Chestnut Lodge before his

move to Yale University was, as I remember it, then mentioning a follow-up study on a considerable number of Lodge patients he and his co-workers at Yale had started and which was subsequently published in the Archives of General Psychiatry (McGlashan, 1984). What he had found out so far was apparently not of the kind to make him feel hopeful about the benefits of a long term individual psychotherapy of schizophrenic patients in a hospital setting. (When I paid a visit to the Lodge some time later I was told that he had even recommended electroshock treatment for one or more of his schizophrenic patients).

There were other contributions which tended to question or at least to relativize the value of mere individual psychotherapy for schizophrenic patients. These were the contributions by *Daniel P. Schwartz*, by *Loren R. Mosher* and *Alma Z. Menn* and by *Paolo Tranchina* and *Paolo Serra*. They all focused on the therapeutic or contra-therapeutic impact of a given hospital and/or social setting in which the therapy - be this an individual or other form of therapy - was to take place.

Schwartz elaborated how an experience of limits is essential for individual growth and identity formation and is most essential for schizophrenic patients whose identity is brittle. He reported on a number of cases in which the setting of limits in a closed psychiatric hospital appeared mandatory as well as helpful. But he also reported on cases in which the setting of limits was overdone, as it were, turning it into sadistic aggression against, and humiliation of, the patient. He further mentioned that the demands of a society needing to protect its members from the psychotic's destructive outbursts on the one hand and therapeutic concerns for his or her growth on the other will often clash and then confront therapists with contradictory mandates and typical dilemmas. These dilemmas differ in closed and open psychiatric hospitals. *Schwartz* reflected in particular on the chances for, and problems of, providing adequate limits in an open hospital such as the Austin Riggs Center in Stockbridge/Mass. in which he was working as an analytically oriented therapist. This hospital provided - and, as far as I know - still provides, intensive, individual psychotherapy of four or more hours each week with an experienced therapist, a very special activities program using sculptors, poets and theater directors as teachers, the presence and focus of nurse-clinicians, community programs and much more. All patients admitted themselves voluntarily and therefore had to learn to develop and trust their inner limits rather than rely on outer limits which the hospital might provide. These and other factors made Austin Riggs a unique place

comparable to the Lodge, but also made it accessible for only a small group of privileged private patients whose growth became the staff's overriding concern.

But the most incisive criticism of long term individual therapy came, no doubt, from *Paul Watzlawick* when he elaborated on the brief therapy of schizophrenia. He supported his position with case descriptions, a comparative analysis of various studies, consideration of the "Here-and-now-communication in schizo-present families" and in his final comments pointed to two epistemologies - one heavily relying on linear causality to grasp intrapsychic processes, the other acknowledging the "fantastic complexity of interactions" - which, in his view, were clashing at the symposium.

In their presentation with the title "Scientific Evidence and System change: The Soteria Experience" *Loren R. Mosher* and *Alma Z. Menn* compared two residential settings for the treatment of schizophrenic patients: The so-called *Soteria House* and an American Community Mental Health Center. But they were less concerned with the question of how either setting could support an ongoing individual psychotherapy but rather with how the given setting, in and by itself, could become the main force in promoting the residents' growth, development and learning.

From this vantage the presenters gave an account of the insights they had gained from the Soteria project which they had started a number of years ago. In essence, this project relied on the democratization of a small community of schizophrenic residents and their helpers who, as a rule, had no significant professional training. This was considered an advantage in their attempts to counteract the residents' medicalization and their becoming pathologized, as would have been the case in a typical psychiatric hospital. Despite criticism from the psychiatric establishment and lack of funds Mosher and Menn could report considerable successes. They also evidently inspired *Luc Ciompi*, another contributor to the symposium, to start the "Soteria project Bern" which Ciompi described for an appreciative audience of about 3500 people at the EFTA meeting held in Berlin about a quarter of century later (cf. Ciompi, 2001).

An even farther reaching project counteracting the trend to medicalize and pathologize schizophrenic patients was reported by *Paolo Tranchina* and *Paolo Serra* from Italy in their contribution with the title "Community Work

and Participation in the New Italian Psychiatric Legislation.” In fact, I do not know of any other events which so massively changed the lives of so many schizophrenic individuals and their relatives as the social and political reforms and their consequences about which Tranchina and Serra reported. These reforms had taken place largely thanks to the efforts of Franco Basaglia who had prematurely died several years before the date of the Heidelberg symposium. Basaglia’s efforts and those of the so-called Arezzo Group had led to a new psychiatric legislation in Italy in 1978 that aimed at the progressive elimination of traditional psychiatric hospitals. Instead, all newly diagnosed psychiatric patients had to be accommodated in general hospitals. At the same time, outpatient community services were to be enlarged and strengthened. In the first year of enforcement of the new law, there had been a decrease of about 17% of the population of the psychiatric hospitals in Italy; this population fell from 52,305 inmates to 43,526. Compulsory admissions had decreased by 63%, declining from 33,287 to 12,244. For Tranchina and Serra, this proved that many of the compulsory admissions carried out in the past had been completely arbitrary.

In their contributions to the symposium the two authors highlighted the many new vistas and chances opened up by the new legislation. In particular, they stressed how the patients’ relatives had become much more prone and motivated to cooperate in the treatment. But they also pointed to the many difficulties and bureaucratic delays which had so far hindered or even prevented the implementation of the new law, not the least because of increased efforts of the pharma industry to push their products into the psychiatric market. All of this - the new vistas and the snarls hindering their practical putting into effect - was in evidence when I, a short time later, visited some psychiatric colleagues in Italy. I vividly remember the old style psychiatric hospitals now empty and looking like deserted barracks. And I also recall the mixture of relief and concern my colleagues conveyed to me. In retrospect, this concern seems justified as Italy has also subsequently been affected by the world-wide upsurge of neuro-biologic psychiatry.

Let me finally turn to the topic which possibly more than any other has made for excitement and salutary (as well as not so salutary) confusion at the symposium: *The topic of family research and family therapy in schizophrenia*. This topic had been on the agenda of previous symposia. This time we were fortunate in that the participants could again learn first hand about the most recent findings and experiences of some of the most innovative researchers and therapists in the field.

Forming a part of these were *Lyman Wynne* and *Margaret Singer* who, in particular with their research on communication deviances, had laid the ground for many subsequent projects carried out by themselves and others. One of these projects was the Rochester Risk Research Program which Lyman Wynne and *Robert E. Cole* presented at the symposium. Its perhaps most interesting and important finding was the elucidation of family relationship variables that promote health in families with children at risk despite the expectable adverse effects which serious parental disorders can be assumed to have on these children. The findings then obtained and the questions then raised by the authors continue to be relevant for what has come to be known “resilience research” in schizophrenia.

Michael J. Golstein - he worked in close cooperation with Wynne and Singer - also contributed to the elucidation of family factors related to the onset and course of schizophrenia. In his presentation with the title “Family Interaction. Patterns Predictive of the Onset and Course of Schizophrenia,” he also elaborated on the importance of communication deviances. Furthermore, he applied the work on *expressed emotion* (EE) as carried out by Vaughn and Leff (1976) with the Camberwell Family Interview (CFI). In addition, he reported on his own work with the *Affective Style* (AS) measure. He evaluated the validity of these constructs from a number of vantage points and finally concentrated on the usefulness of the affective style construct. He concluded: “Families in which significant others, usually parents, express strongly critical and/or emotional overinvolved (intrusive) attitudes are at a higher risk for onset and relapse for schizophrenia.” However, his data also indicate “that these affective attitudes predict schizophrenia only when associated with high levels of communication deviance.”

The work of *Pekka Tienari and his associates* from Finland also gave evidence of the importance of communication deviances in child rearing parents as one major risk factor predicting a child’s later development of a schizophrenic (or schizophrenic spectrum) disorder. I know of no other research in the field of psychiatry comparable to it in scope, length of time invested, methodologic stringency and number of variables examined. In his presentation with the title “The Finnish Adoptive Study: Adopted-Away Offspring of Schizophrenic Mothers”, Tienari and his associates reported on the progress of the field work. By then, a national sample of 274 Finnish, adopted away offspring of schizophrenic mothers had been identified. One hundred fifty three of these offsprings of 134 mothers had been placed in an

unrelated family during their first 4 years of life and were at age of risk for schizophrenia when the symposium took place. The main finding was that the index and control groups did not differ if they had been brought up in relatively undisturbed adoptive families; but if the rearing family was more disturbed, the index adoptees were clearly more disturbed than the control adoptees.

Let me turn from the research on families with a schizophrenic offspring to the experiences made with the therapy of such families as these were reported at the symposium. Three approaches stood out here, all markedly differing from each other.

The first approach, presented by *Mara Selvini-Palazzoli* and *Giuliana Prata*, has since come to be known as the "Invariant Prescription." This intervention typically comes as a surprise to the family members as it requires that only the parents and not their schizophrenic offspring come to the next session. This prescription, the authors stated, "seemed to break the ongoing game (in the family) without it being necessary for the therapist to first understand what game has been going on." By the time the symposium took place, the authors had applied the prescription to 19 families.

The second approach was presented by *Norman L. Paul* in his contribution with the title "The Unconscious Transmission of Hidden Images and the Schizophrenic Process." This approach is based on a transgenerational perspective of the genesis of a schizophrenic process which Paul exemplified by one particular family. It was guided by the hypothesis "that the repressed mourning responses in family members (usually parents) are related to a fixity in family structure or equilibrium which precludes the formation of adequate ego boundaries on the part of family members."

The third approach was presented by *Carol M. Anderson* from Pittsburgh University. She called it "A Psychoeducational Model of Family Treatment for Schizophrenia" and gave an overview of the - in her view very promising - results obtained with it in the first three years of its application. This approach, Carol Anderson pointed out, can be applied in diverse ways and diverse settings. Yet it does require a particular kind of training that often flies in the face of clinical instincts and learned therapeutic roles. That notwithstanding, it has been this approach which in hindsight appears to have developed further and to have established itself most strongly in the mainstream of the international family therapy movement. Yet when taken

together, all three approaches just mentioned could, in their diversity, hardly be seen as reducing the confusion, be it salutary or not salutary, reigning at the symposium.

I conclude my report with two contributions, which, in contrast to the above, can be seen as attempts to integrate and/or reconcile different forms of treatment as well as the different theoretical positions underlying these treatments. These are the contributions made by *Yrjö Alanen and his Finnish co-workers* and those of *our team in Heidelberg* as I presented these at the symposium.

Alanen's and his team member's work was presented under the heading "Psychotherapy of Schizophrenia in Community Psychiatry: 2-Year Follow-Up Findings and the Influence of Selective Processes on Psychotherapeutic Treatments." This work then included the psychiatric and psychological investigators of 100 patients, aged 16-45, who during the preceding one and a half years had entered treatment for the first time for a disorder included in the group of schizophrenias. The treatment took place in an inpatient and/or outpatient unit. In 90 out of 100 cases, these patient's closest family members were also interviewed. The treatments included individual therapies, family therapies and, no less important, the active participation and cooperation of the psychiatric staff, the patients and close family members who were affected. Thus, one can speak of a treatment setting and context which tried to do justice to what, up to that time, had appeared to be (more or less) separate if not incompatible approaches to the understanding and treatment of schizophrenia: The individual approach, the family approach and the community approach. As it turned out, these were just the beginnings of a study which, with respect to its findings as well as to the questions it raised and still raises, continues to be unique, as can also be ascertained from Alanen's book "Schizophrenia - Its Origins and Need-Adapted Treatment." (Karnac Books, London, 1997).

In addition, the efforts of *our Heidelberg group*, presented under the heading "Reflections on the Family Therapy of Schizo-Present Families" could - and still can - be seen as attempts to embed a given treatment, in this case predominantly family therapy, in a theoretical perspective which, in addition to family factors, takes into account both individual as well as societal factors which may either promote or interfere with a person's growth and survival. And I, too, tend to see the work then presented as a beginning which has since branched out in various directions as is, for example, exemplified

in my most recent book “The Democratization of Psychotherapy” (so far published in German only) and which also can be seen as perpetuating the confusion generated by the 1981 symposium - a confusion which, I believe, was salutary after all, not the least because of the excitement, the warm feelings, the mutual respect and the humor engendered again and again.

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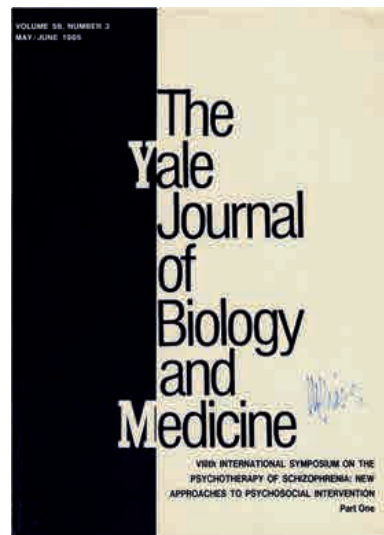
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CHAPT. 8 PHOTOGRAPHS



Lidz and Fleck, Chairmen of New Haven Symposium. 1984

Works of 1984 New Haven Symposium were published in two issues of The Yale Journal of Biology and Medicine.



8. The VIIIth ISPS Symposium In New Haven, Conn., U.S.A, in October 1984

Ann-Louise S. Silver and Stanley Possick

The VIIIth International Symposium on Psychotherapy of Schizophrenia was held in New Haven, Connecticut in October, 1984. Under the leadership of Stephen Fleck, M.D. and Theodore Lidz, M.D., it was the first of these symposia to take place in the United States. Fleck commented, "...interest in the psychotherapy of schizophrenics is rather low in the United States compared with Europe, a reversal in orientation and research in the two areas over the last quarter-century." (p. 207) Three hundred participants from throughout the world convened in New Haven to learn about and discuss the central theme of the conference, new approaches to psychosocial interventions in the treatment of schizophrenia. Ninety of the participants presented, co-presented or discussed papers or case presentations. They are listed at the end of the two-issue set of papers issuing from the meeting, many of whom continue as major contributors to our field. Given the waning interest in, and support for, individual psychotherapy of schizophrenia in the United States at the time, coupled with declining research funding in the area, this Symposium provided an important venue for national and international leaders in the field to illustrate and document the efficacy of various psychosocial interventions in the treatment of schizophrenic individuals. Presenters raised fundamental questions about developmental and psychosocial factors in the etiology and course of schizophrenia, leading to productive discussion.

Nineteen of the approximately eighty manuscripts presented at the conference were selected for publication in two successive issues of *The Yale Journal of Biology and Medicine*, volume 58, numbers 3 and 4, published in May-June, 1985 and July-August, 1985 respectively. The first issue focuses on theoretical and epidemiological topics. The second issue addresses treatment issues and program evaluations. The Symposium's Editorial and Program Committee and the Editorial Board of the *Journal* selected the papers to be published, and Stephen Fleck, M.D. served as the guest editor

for these two issues of the Journal. The Editorial and Program Committee, which also selected the main theme for the Symposium and decided on its format and manuscripts to be presented, consisted of: Drs. Yrjö Alanen (Turku, Finland), Stephen Fleck (New Haven, Connecticut), John Gunderson (Boston, Massachusetts), Jarl Jørstad (Oslo, Norway), Ira Levine (New Haven, Connecticut), Daniel P. Schwartz (Stockbridge, Massachusetts), Helm Stierlin (Heidelberg, Germany), Pekka Tienari (Oulu, Finland), Endre Ugelstad (Oslo, Norway) and Lyman Wynne (Rochester, New York).

The Symposium could not have taken place without the support and assistance of the Yale University School of Medicine, its Department of Psychiatry, which was chaired by *Morton Reiser*, M.D., and the Yale Psychiatric Institute. All of the plenary lectures, case presentations, panels and paper presentations were held at various facilities at the medical school.

The work of the local arrangements committee played a crucial role in the success of the Symposium. This committee consisted of: Mr. *Lawrence Berger*, Ms. *Mady Chalk*, Drs. *Stephen Fleck*, *Charles W. Gardner*, *Ira Levine*, *Theodore Lidz*, *Stanley Possick* and *Robert Rosenheck*. This group took responsibility for the moment-to-moment operations of the Symposium, and also organized the social activities associated with the conference. The members of this committee wanted to stimulate as much dialogue and interaction as possible among the Symposium participants and the local mental health practitioners and scholars. The fact that nearly a third of the attendees presented at the Symposium facilitated this process. Those of us, who had participated in previous I.S.P.S. symposia and who had been welcomed as guests into the homes of our hosts, had found these to have been warm and meaningful experiences. Many of this committee's members and several of our senior colleagues had dinners at their homes for as many of the participants as possible. We tried to include a mixture of local mental health professionals, who had an interest in work with schizophrenia, with out-of-town and international guests at each of the dinners. The dinner parties took place the night before a gala dinner dance at the New Haven Lawn Club, and were a highlight of the Symposia.

The presentation of five case reports, each followed by a panel discussion, was one of the organizing principles of the conference. The case material illustrated how clinicians in various countries utilized different psychosocial interventions, e.g. individual, group, family and milieu therapies in the treatment of schizophrenia. The clinical cases brought the work we do to

life, and the subsequent panel discussions allowed one to link clinical techniques with theory. One of the clinical presentations consisted of a simulated family therapy session, which was then discussed. *Christopher Keats*, M.D., of Chestnut Lodge, played the role of the patient. Over the years, he has often commented on how easy it was for him to “become” the patient, and how he really lived the part in the moment. He clearly enjoyed the experience and enjoyed recalling it.

The breadth of the paper topics presented at the conference is captured by the wide variety of subjects noted in the titles of the Symposium’s published manuscripts. These include: individual, family, group, milieu and combined pharmacologic and group or individual therapy, the Schreber Case, the Finnish Adoptive Family Study of Schizophrenia, and two other important follow-up studies: the effects of supportive versus insight-oriented psychotherapy of schizophrenia and the development of a global psychotherapeutic approach to schizophrenia. At least three of these papers have been associated with research that has had a major impact on the field during the past twenty years. Together, these representative papers convey the richness and diversity of the meeting’s formal offerings. Even though we have no published record of the case presentations, the papers that were published are rich in vivid case presentations and vignettes. We will review the published articles since the journals themselves may be very difficult to locate.

Theodore Lidz delivered the keynote address, a message still vitally current twenty years later: “The address considers the regression that has taken place in American psychiatry during the second half of this century, one which has resulted from attempts to locate the origins of many psychiatric disorders in the brain, and particularly from the misguided attempt to revitalize the nineteenth-century conviction that schizophrenia is a clear-cut disease entity that is chronic and incurable. The orientation has again become self-fulfilling because of the relative neglect of psychosocial therapies.” (p. 209) He saw the reason for the regression as “a misunderstanding of the nature of human adaptation that rests greatly on the capacities for language.” Children need to acculturate, and the responsibility for this rests with the parents; failures in this project lead to “escape into a fantasy life” and the resultant clinical picture we call schizophrenia. Lidz decried the over-reliance on medication and the closure of hospitals, with the result that homeless mentally ill then filled the cities of the U.S. He refuted the earlier adoption studies, emphasizing the very low

rate of schizophrenia in adopted-away children of schizophrenic mothers. He yearned for a return to the orientation taught by Adolf Meyer, who emphasized the central role of life history. He gave case vignettes illustrating recoveries from this so-called incurable condition. He quoted Leon Eisenberg, "Our field has changed from a brainless psychiatry to a mindless psychiatry." He then launched into the body of his talk, developing the notion that human brains differ from other primates in that we use and develop tools, the most important being the word – language. We can consider past, present, future, and can communicate our thoughts; we can adapt to our environments, but we must adapt to our own cultures to survive, and we need our families to accomplish this. Lidz detailed his professional path to working with families of schizophrenic patients, and his finding that all had one very egocentric parent. He himself was routinely confused in their presence. "The fault is more likely to be in the programming than in the hardware." (p. 216).

David Adler (1985) presented "A framework for the analysis of psychotherapeutic approaches to schizophrenia." He describes the four major tasks of psychiatry and then demonstrates how these tasks overlap and interdigitate. They include a) the medical perspective: diagnosing, curing and limiting illness; b) the rehabilitative perspective, reducing defect and its impact; c) the educative-developmental perspective, fostering growth and competence, and d) the societal-legal perspective, controlling socially deviant behavior. "...a comprehensive approach to the psychotherapy of schizophrenic individuals must take into account the many ways in which the schizophrenias are at the same time a disease state, a defect, a cluster of behaviors labeled as deviant, and a developmental impairment." (p. 219) "Physician/patient relationships often reflect a benign paternalism." (p. 220) "One emphasis of this paper has been that technique does not define an area of psychotherapeutic work even or especially with schizophrenic patients. For example, if the focus of treatment is on disturbed functioning, then the work is more often rehabilitative, whether the techniques used are exploratory or supportive. Restoring the individual to an adaptive equilibrium, maintaining control, alleviating symptoms, as well as strengthening existing defenses, are goals of treatment. The relationship between therapist and patient is utilized to promote functional improvement." (p. 225)

Pekka Tienari et al (1985) presented on the early phase of their famous "Finnish adoptive family study of schizophrenia: "A nationwide Finnish sample of schizophrenic mothers' offspring given up for adoption has been

compared blindly with matched controls; i.e., adopted-away offspring of non-schizophrenic biologic parents. The families have been investigated thoroughly by joint and individual interviews and psychological tests. In the 91 pairs where both the index and control families have already been investigated and rated, the total number of severe diagnoses (psychosis, borderline, character disorder) is 28.6 percent (26/91) in the index group and 16.5 percent (15/91) in the matched control group. Of the seven psychotic cases, six are offspring of schizophrenics and only one is a control offspring. However, no seriously disturbed offspring has been found in a healthy or mildly disturbed adoptive family, and those offsprings who were psychotic and seriously disturbed were nearly all reared in disturbed adoptive families. This combination of findings supports the hypothesis that a possible genetic vulnerability has interacted with the adoptive rearing environment.” They underscored the possible interaction between genetic vulnerability to schizophrenia and adoptive rearing environments in adopted-away offspring of schizophrenic mothers. They list (p. 236) three alternative interpretations of the findings: 1) “Genetically transmitted vulnerability may be a necessary precondition for schizophrenia, but a disturbing rearing environment may also be necessary to transform the vulnerability into clinically overt schizophrenia.” 2) Healthy family rearing is a protective factor. 3) “Another possibility is that the genetic vulnerability of the offspring manifests itself in a way that is disturbing to the adoptive family.” However, there were just about as many disturbed families adopting a vulnerable child as there were disturbed families adopting a child not at risk. They reported that a major subset of their group had not grown to an age when schizophrenia usually manifests itself. They promised, and have since delivered, much rich research material.

“Intensive psychotherapy of schizophrenia,” presented by *Christopher Keats* and *Thomas McGlashan* was a prelude to their book, *Schizophrenia: Treatment Process and Outcome*. “This work is part of a larger study in which we are searching for clues as to what elements in the process of treatment might contribute to outcome.” (p. 239) They begin by outlining the assumptions that most frequently appear in the literature: 1) “the etiology and pathogenesis of schizophrenia are, in part, environmentally influenced. 2) the therapist’s model of the mind draws heavily upon theories and observations concerning preoedipal psychological development. 3) virtually all postulate a real or fantasied negative first experience between the patient-as-infant and his or her mother. 4) “utter schizophrenia does not exist....even the ‘craziest’ of patients retains an element of ego in touch with

reality.” (pp. 239-240) They find in the literature that generally a good patient has “1) an ego-dystonic illness leading to a wish for treatment; 2) the presence of good premorbid features; and 3) the presence of some capacity for one or more of the following: self-observation, curiosity, delay, frustration tolerance, problem solving, attachment, concern, and humor.” (p. 240) They then reviewed the elements of the therapeutic process and the technical attitudes of investigative psychotherapy. “The patient holds all the trump cards. Therapists must tolerate negativism and ultimately accept the patient’s right to psychosis. Especially with chronic patients, it is important to realize that the person is the illness rather than host for the illness. Psychosis is often ego-syntonic and deeply cherished like an old familiar security blanket. Getting better therefore is like a death, like losing an old friend.” (p. 241) They then discuss technical interventions. “The component strategies of elucidating,” include 1) listening and observing, 2) treating psychotic content as signal, 3) acknowledging feelings, 4) elaborating detail, 5) demanding facts, 6) tolerating the mobilized transference and countertransferences.” “By demonstrating tolerance of what the patient disavows, the therapist helps the patient repossess split-off aspects of his psychic experience.” (p. 243) They then present an elegant, experience-near, case history of a man who recovered from chronic and severe schizophrenia, over the course of a long hospitalization at Chestnut Lodge. “Perhaps one reason for the successful outcome of the second regression was that the patient and therapist shared a real experience, namely, despair, and survived, thus accomplishing something together.” (p. 252)

Helm Stierlin et al presented “Why some patients prefer to become manic-depressive rather than schizophrenic.” The authors observed fifteen families where a young adult member suffered from manic-depressive illness. Systemic family therapy was utilized, using the circular questioning method of Selvini-Palazzoli. They observed families operating by a “digital code” similar to the on-or-off of computer coding: “a person is either good or bad, honest or dishonest, controlled or uncontrolled, responsible or irresponsible, and so on. There is no in-between.... Related to this “is the notion shared by all members that one can and must ‘will’ certain emotions. Interpersonal and intrapsychic negotiation thus becomes impossible, and intolerable emotional dilemmas result....Manic-depressive families...live in a world of mutually exclusive yet constantly reconstructed extremes—extremes in attitudes, roles, behaviors, and values.” (p. 260) The authors see the goal of family treatment as fostering individuation by questioning the family members’ assumptions.

Bjørn Rund "Attention, communication, and schizophrenia" has carefully investigated the cognitive disorders in schizophrenic patients and the communication deviances in their parents, finding significant correlations between them. He set up an experiment guaranteed to produce the communication conflicts he wanted to study: Each parent was given a map but the father's had an extra street. They are supposed to navigate to a particular spot. Rund studied how they negotiated and possibly solved the dilemma. He has concluded that his work supports Vigotsky's theory that higher mental functions are internalized social relations. This resonates beautifully with the preceding paper dealing with the manic-depressive disorder.

Michael Stone "Analytically oriented psychotherapy in schizotypal and borderline patients: At the border of treatability" studied the positive and negative factors distinguishing the likelihood that a treatment relationship could be established. "On the positive side: likeableness, autoplasmic defenses, high motivation, psychological-mindedness, genuine concern, good moral sense, self-discipline and low impulsivity. Negative factors include, beside the opposites to the aforementioned, vengefulness and parental abusiveness or exploitation. A scale for measuring the balance between these positive and negative factors is proposed." (p. 275)

Nancy Morrison, "Shame in the treatment of schizophrenia: Theoretical considerations with clinical illustrations" is a paper we feel should be rescued from the relative oblivion of this journal article, to be read by current trainees in mental health. It clearly and convincingly demonstrates how the universal experience of shame is central in the development of schizophrenia. It plays "a vital role in autonomy and personality development, symptom formation, character pathology, and interpersonal relationships. "Shame is a reaction involving hiding, and this has led to its hiding from psychological observation. It damages the boundaries of the self and it incorporates the opinions of the other into the self-experience. It produces "humiliated fury," but when this is towards someone on whom one is dependent, passivity can result, and escalating shame can result, leading to chronic self-doubt and interpersonal inhibition. Clinical examples are given that show that when the therapist highlights shame and self-consciousness, the level of collaboration can improve dramatically.

James Grotstein "The Schreber case revisited: Schizophrenia as a disorder of self-regulation and of interactional regulation." Rather than getting locked

into debating whether schizophrenia is a disorder of nature or nurture, Grotstein hypothesizes primary and secondary disorders of attachment, presenting as disorders of self-regulation and interactional regulation. The paper, following that of Nancy Morrison, can be seen as an amplification and development of her thesis as well.

The second Journal issue contained seven articles:

Marvin Skolnick, "A group approach to psychopharmacology with schizophrenics" showed how the over-worked ward administrator can use group techniques to move the act of medicating from something in which the doctor is the active and the patient the passive partner, to an activity in which other patients can make the psychologically meaningful interpretations about resistance to receiving these substances, thus helping not only that particular duo but the other community members as well. "It is not just the medication that needs to be metabolized by the patient. The dynamic forces within the system must be metabolized by the pharmacotherapist and in a coherent way brought back into the treatment if the patient is to be helped by medication and not harmed." (p. 326)

John Cegalis and *Stanley Possick* presented "Carbamazepine and psychotherapy in the treatment of schizoaffective psychosis" "The authors describe the interactions between and the differential effects of carbamazepine and individual psychotherapy in the treatment of a schizoaffective patient. Carbamazepine's impact on the patient's affective life facilitated the establishment of a working alliance in psychotherapy. As the patient began to understand and differentiate aspects of his affective, cognitive, bodily and interpersonal experiences, his life situation stabilized and his carbamazepine dose requirements diminished." (p. 327).

Pier Maria Furlan and *Gaetano Benedetti*, "The individual psychoanalytic psychotherapy of schizophrenia: Scientific and clinical approach through a clinical discussion group" describe an ambitious and effective long-term support system for psychotherapists treating patients struggling with schizophrenia, which harkens back to Clara Thompson's 1938 "Miracle club," and to the Chestnut Lodge small group meetings. Fourteen years of working in a clinical supervision group allowed for the careful study of the very personal and complex nature of this psychoanalytic approach. "Each meeting was dedicated to the discussion of one particular therapy carried out by a member of the group and written up in advance. After the general

discussion, the group leader presented both his previously written assessment and a synthesis of the discussion. All the discussions were recorded in their entirety." They documented the presence of symbiosis, and saw it as predictive of a good outcome. Case examples are given, but one wishes the transcriptions could be made available, as a model of excellent instruction.

Per Vaglum et al, "Why are the results of milieu therapy for schizophrenic patients contradictory? An analysis based on four empirical studies." The authors found that the contradictory findings can be explained when one looks at the varying ward "atmospheres." Anger and aggression impede, while support, practicality, and order are positive. Confrontational group therapy is detrimental. "Community groups may become anti-therapeutic pseudo-groups." Having more older patients diminishes the level of aggression. "A high percentage of psychotic patients, a high number of patients, and a high staff turnover may lead to a detrimental atmosphere." (p. 349)

William Wilson et al "A psychotherapeutic approach to task-oriented groups of severely ill patients" contains much wisdom in guiding the group leader working with psychotic patients. The group leader must be much more active and structuring than when working with a less sick group, and "must actively work to provide for the structure, stability, and safety of the group when group members are unable to provide these for themselves." (p. 363.) The paper includes helpful illustrations.

John Gunderson and Arlene Frank, "Effects of psychotherapy in schizophrenia" presented data that was part of a two year follow-up study which hypothesized that insight-oriented individual psychotherapy would be more efficacious than supportive therapy in the treatment of medicated schizophrenic patients. The authors found little difference between the two groups at follow-up (Stanton et al., 1984; Gunderson et al., 1984). This study, and discussions of its findings, was the focus of an entire issue of *Schizophrenia Bulletin*, and it stimulated far-reaching dialogues about the value of insight-oriented psychotherapy in the treatment of schizophrenia.

Yrjö Alanen et al, "Developing a global psychotherapeutic approach to schizophrenia: Results of a five-year follow-up" described a five year follow-up study of 100 schizophrenic patients, who were divided into four subgroups. Alanen described five modes of psychosocial treatment, which, in conjunction with medication, were found to be optimal for different patient

groups. This work culminated in the establishment of Alanen's model treatment for schizophrenia: Need Adapted Treatment (Alanen, 1997).

We hope this summary of the VIIIth International Symposium on Psychotherapy of Schizophrenia has given the reader some sense of the richness and diversity of the conference. Reading through these diverse papers, each conveying an intense devotion to scholarship and clinical acumen, conveys the deep commitment of the membership of ISPS to the clinical task of understanding and helping individuals who struggle with psychosis. Even though the case presentations were not included in these two issues, the reader still "comes away" from this meeting strengthened by the variety of perspectives presented, which were often strengthened by well thought-out research projects.

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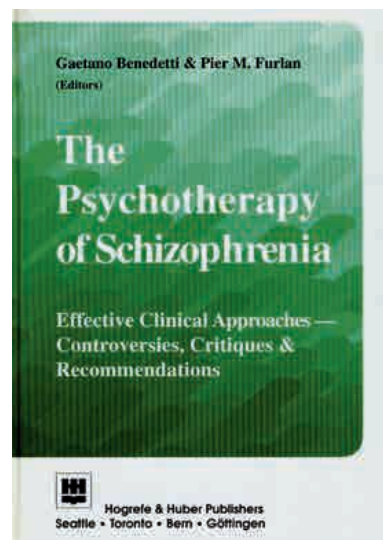
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Gaetano Benedetti



*Book of ISPS Symposium
in Turin 1988*

CHAPT. 9 PHOTOGRAPHS



*Audience of Turin
Symposium with P.M.
Furlan and G. Benedetti*



*Pier Maria Furlan.
Chairman of Turin
Symposium*

9. The IXth ISPS Symposium in Turin. Italy, in August 1988

Approaches to Psychosis: from the One-to-One Laboratory to the Psychosocial Models

Pier Maria Furlan

There were a number of reasons for deciding to host the IX edition of the ISPS Symposium in Turin.¹

For many years *Gaetano Benedetti*, the Italian-born psychoanalyst and Professor of Psychiatry at the University of Basel, Switzerland, had been running training programmes on borderline and psychotic pathologies in Italy, especially at the Centro Studi di Psicoanalisi in Milan², at various Universities and private³ and public medical facilities. Psychoanalytical theory had always been highly regarded in Italy but was often limited to individual training and less accepted at an official institutional level. Most of the university psychiatric units were oriented towards biological and behavioural theories with a few exceptions, such as Florence, Genoa and Pavia, whose directors were members of the Psychoanalytical Association or open to social problems like in Bologna and Milan.

The favourable reception in the VIII ISPS symposium at Yale University in the U.S., both with regard to our group and to the research presented, and the encouragement of historical figures such as Ruth and Theodore Lidz, Stephen Fleck, as well as the fear that the Italian experience in individual psychotherapy could be missed in favour of family oriented care, outweighed any resistance.

¹ Turin, founded by the Romans and elevated to the status of City by the Emperor Augustus, was the first capital of Italy after being the capital of the Kingdom of Savoy. Built as a *castrum romanum* is graced by many baroque palazzi and is close to the Western Alps and high mountains such as Monte Bianco, Monviso, Monte Rosa, Cervino (the Matterhorn).

² In particular: Teresa Corsi Piacentini, Lidia D'Alfonso, Ciro Elia, Anna Maria Fabbrichesi, Guido Medri and Aldo Cantoni in via da Giussano, Milan

³ One of the first institutions was the Centro Milanese per lo sviluppo della psicoterapia in Milan.

Benedetti, as a member of the board, put forward the candidature of the University of Turin and the Centro Study in Milan, seconded by David Rubinstein, a Cuban-born U.S. psychotherapist interested in our research.

Given that Benedetti, nearing the twilight of his university career, wished to host the symposium in Italy, his contagious enthusiasm led us to underestimate the difficulties we would face. Generally these difficulties were ideological and economic; locally they came from the university context, as we will see below. Moreover, the regional health administration was not supportive and provided no funding. The banks and insurance companies refused sponsorship on the grounds of image (life insurance does not cover mental illness) and the only possibility of help came from the pharmaceutical firms. On the other hand, asking for support for a symposium based on “psychotherapy,” risked being interpreted as against “psychopharmacology.” Our university clinic in Turin, biologically oriented, was very suspicious of other treatments for schizophrenia with all decisions being taken by the director, a full professor of psychiatry (at the time I was associate professor of psychiatry).

The real work of organisation started one year later and the first issue we had to deal with was the format of the symposium. The first three symposia held in Switzerland were meetings of experts focused on defining the inner methodology and the specificity of this approach to schizophrenia. This rationale was gradually broadened in the later symposia and the attendance extended to include people working in public healthcare facilities, interested in the social aspects as well as in individual or group dynamics. The Attendance at Yale rose to 250. The possibility and desire to increase enrolment led to plan the budget for a much larger conference in Turin. This planned enlargement led to some apprehension and debate on the part of those who feared a change in the spirit of the symposium.

Alongside the financial necessities, were a number of cultural and contextual factors. Until the 1970s little psychodynamic literature had arrived in Italy or been translated into Italian. Apart from occasional publications of works by Sigmund Freud after World War II (by Fratelli Bocca Editori) and of books dealing with social problems from a psychoanalytical point of view, such as those by Weiss, Musatti, Servadio, there was no systematic body of publications on new trends in psychiatry. Not only was psychoanalysis hardly accepted in academic circles, but even psychiatry was dominated by neurologists who considered psychiatrists as second class doctors. Part of this situation was also due to the cultural conservatism of

the Italian Psychoanalytical Association interested in the preservation of “analytical purity.” It was thanks to a few young pioneers, who had studied in Switzerland⁴ and come back, that there was a major transformation in outlook. *Pier Francesco Galli*, Benedetti’s first Italian pupil, founded and edited the first series of psychodynamic books ever translated in Italy (publishers Feltrinelli and Boringhieri) and in Milan in 1970 he organised the International Congress on Psychotherapy. This new approach had an important impact on young doctors in Italy, many of whom decided to receive psychoanalytical training, even outside the official Italian associations. Therefore their studies had been oriented by the theories and research of many of the luminaries who had participated in the previous symposia and for us, the organisers, it would have been inconceivable to organize such a conference in Italy for only a small group of participants. Furthermore, for many of us, involved in the heated debate over the closure of the mental hospitals, it seemed essential to demonstrate the centrality and implication of social and psychodynamic factors in mental illness.

One of the first decisions taken with Benedetti was to open the symposium to all the professionals with an interest in the field, doctors and psychologists in training and even students. Many of the leading figures of the symposium were a little suspicious of this change in the typology of attendance. In Italy the situation was more complex and a short description of the situation seems necessary in order to understand better the background to the decision to host the symposium and to further development of its format.

Psychiatry in Italy: Historical Background

Medical attention towards poverty and mental illness started nearly contemporaneously in the capitals of the great Italian kingdoms and principalities in the middle of the eighteenth century, and moral psychiatry was developed in some hospitals allocated in hygienic and rationally built facilities, even far before the well known transformations introduced by Pinel in the Salpêtrière. Vincenzo Chiarugi wrote an important book about

⁴ It is important to emphasize that the school of psychology was advanced and well accepted and that some of the leading new psychiatrists came from this background, such as Pier Francesco Galli, Enzo Codignola, Silvia Montefoschi, Giambattista Muraro, Emanuele Gualandri, GiamPaolo Lai, Mara Selvini Palazzoli, Vincenzo Morrone just to mention a few.

the rights of his patients in Florence in 1785 where the facilities were very humanitarian. Psychiatric illness found a place in medicine different from the courtyards of churches, prisons, asylums for beggars and vagrants or even the roads. In Turin in 1838 King Carlo Alberto built a mental hospital designed by an innovative architect aware of the importance of cleanliness and medical hygiene, even though the result was more similar to a military barracks. However, the quality of the hospital depended on the magnanimous attitude of the prince and not on medical advances.

The first professor of psychiatry (the director of the mental hospital) was appointed by the University of Turin in 1870, but we had to wait until 1904 for the first national psychiatric law which stated that all the provinces ought to have at least one hospital, with two doctors and nurses and that patients had to be hospitalised with respect and compassion. Some of the nineteenth century mental hospitals were like self-contained cities, with small factories and workshops run by both lay and religious staff (Opera Pia). The hospital had to maintain some hygienic and medical standards, even if all the admissions were compulsory and motivated by "dangerousness toward themselves and others and being a public scandal;" the consequence of the hospitalisation was the loss of civil rights and a life long police record. However it seems important to underline that at this time the law was an important new step in the government's policy towards the care of social problems.

An internal immigration, which lasted more than a hundred years and started with the unification and the transformation from an agricultural and "latifondo" economy to an industrialized state, led to inequalities and deep changes in the social organization. The asylums were full of "Pellagra" disease due to a mono alimentation with corn, not recognized as such by the dominant Lombroso school. The creation of more than a hundred mental hospitals, which in general were able to offer a higher life standard than that of the population, has still to be considered as remarkable progress. However, Italian psychiatry was increasingly influenced by German psychiatry, pessimistic about therapeutic possibilities; psychoanalytic thought was not accepted by academics⁵. Between the two world wars the

⁵ I remember my professor of psychiatry when a student; one of his favourite jokes was "Freud? I have never heard this name." In the sixties we all were specialists in Neurology and in Psychiatry and only after the mid seventies did psychiatry reacquire importance, becoming compulsory in the medical training, attracting attention in the mass media, becoming the object of political debates.

custodial role triumphed over the medical role and thus the degradation rapidly increased, in some places beyond any imaginable description. Some of the mental hospitals in the fifties and sixties were the worst kind of asylum, very often without any respect for basic sanitation and health requirements. Psychiatry had an administrative status and budget separate from that of the rest of the health service; it was considered an inferior branch of medicine and psychiatrists were paid less than other doctors.

The degradation was becoming evident and the pharmacological progress of the fifties did little to halt the deterioration. Of course it is not true that all those who went in never came out, but they were certainly admitted into a circuit which, besides degrading them, also degraded the facilities and all who worked there. The illness and its treatment created still more illness and still more degradation.

In many regions in my country, we started with the dehospitalization process in the late sixties, understanding that more than sixty percent of the people hospitalised in the large mental hospitals were not psychiatric patients but just represented one of the weakest parts of the population. More than a hundred thousand patients, one patient per every four hundred citizens, were in more than a hundred and twenty mental hospitals all over Italy. Under the influence of the students movement of 1968 the new generation of psychiatrists, nurses and social workers started a strong campaign in mental hospitals to humanize the care system. We obtained the approval for a popular referendum against the Manicomi (the Mad Houses) and thus, to avoid what was considered a political risk, the parliament in 1978 approved a law which promulgated the transformation of the hospital centred psychiatric care model into a community oriented system, with the closure of mental hospitals, the introduction of a psychiatric ward in the general hospitals, the need to centralise psychiatric care within the local district and the diffusion of mental health centres all over the country. (It was the so-called *Basaglia Law* or *Law 180*, which was then included in the General Health Reform).

The psychiatric reform started with a great enthusiasm but at least for a decade was in progress in a different manner in different parts of Italy. Franco Basaglia died in 1980 and the difficulties to organise a psychiatric community oriented system, after the first enthusiastic period, became more and more evident. Many general hospitals were not in favour of the introduction of a psychiatric ward and hospital doctors were against the care

and “triage” of mental health patients in the emergency room; for these professionals a “psychotic crisis” had nothing to do with a “stroke.” especially in the emergency room. Furthermore part of the public opinion still considered mental illness as synonymous with dangerous behaviour and politicians were afraid of the unknown economic effects of such a transformation; in fact the old mental hospitals, even if they no longer accepted patients, lasted for twenty years more, and thus the welfare system (the public health system in Italy was and still is free of charge for all citizens) had to maintain a kind of “double system” for mentally ill patients. Finally, the professionals who used to work in the mental hospitals, moving to the community, were disoriented because of the lack of clear indications about the community system, and the enthusiasm of part of the young doctors was not sufficient to cope with the daily increasing difficulties.

We had to find the space in the crowded general hospitals to put the psychiatric ward in, and we had to change the mentality of the other non-psychiatrist doctors and staff members. Certainly the result, on the one hand, was that a number of the psychiatric wards were located in improvised and inadequate situations, but, on the other hand, this sudden and compulsory introduction strongly reduced the stigma towards both psychiatric staff and patients. This introduction led to the spread of liaison psychiatry and, of course, to the consideration of the psychiatric operator as a peer by the rest of the general hospital staff. It should be pointed out that the reform law was a political act and did not indicate the methodology, resources and administrative tools, which were left to the local administrations, more precisely to the parliaments of the twenty Regions into which Italy is divided. The first local law was written in 1988, and some regions drafted their local administrative guidelines ten years later. The growth of mental health services was completely undifferentiated, followed local and personal initiatives, and the resources necessary to build mental health organisations were arbitrarily assigned by the local policy makers.

The tepid involvement of university teaching hospitals, as said before, determined a cultural gap in the training of young doctors and psychiatrists; they received classic Jasperian and Bleulerian psychiatry, while the “every day” psychiatry outside the universities was different. Other colleagues, attracted by progressive psychiatry were, to some extent, influenced by the seductive paradoxes of anti-psychiatry and by the conviction that the aetiology of mental illness was just round the corner, the corner of the mental hospital wall. It was an ideological conviction, which was to be

revealed as only partially true for a part of the pathology, but which proved to have the power to overturn the economic interests, the social fears and the political resistance of the period.

Thus many of the specialists in neurology and psychiatry (we had to wait until the middle of seventies for the separation between the two specialties), not satisfied with their training, decided to have a personal psychoanalytical training and not necessarily with official members of the International Society. Leaving aside the great differences in the quality of what was offered, we had to cope (and still have to cope) with many problems: how to introduce and how to provide psychotherapy in a public service and in a community care organization. The request for personal psychotherapies from the new generation of psychiatrists increased enormously. Many private schools were opened by colleagues who had been trained in France, Switzerland, Germany, the United Kingdom. In a study conducted by me in 1985 we found that more than half of the doctors working in the community services had had personal psychoanalytically oriented treatment and over two years of training in psychotherapy, even if not officially recognized by the national or international associations. On the contrary just ten percent of the colleagues still working in mental hospitals had received similar training, even if they were expected to transfer to the community services. Finally one of the effects of the introduction of community psychiatry was the growth in demand for treatment by younger patients, a kind of pathology which was unknown by many psychiatrists who used to work in the mental hospitals. All these were the most important factors that contributed to the decision to enlarge the number of enrolments and to open the Symposium to everybody interested in the field.

Practical arrangements

The final change in our planning work was the decision to postpone the Symposium for one year – from 1987 to 1988 - which also stemmed from a personal interest: the fact that the medical school of Turin University was duplicating its facilities in a former Tuberculosis hospital near the city, the San Luigi Gonzaga Hospital, able to host part of the growing number of students. I was trying to obtain the possibility to include the teaching of psychiatry and to set up a community oriented mental health service, and thus to apply the psychiatric reform for the first time at a university level. Furthermore the responsibility for the organisation of the symposium

depended mainly on my few young collaborators⁶ and myself, since it was difficult to collaborate on an effective daily basis with the Milan group and its members who, in turn, lived in several other cities in North Italy. A young lecturer from Oxford University, *Dr Martin Solly, Ph. D.*, resident in Turin, helped my basic English (and he still is the reviser of this paper) and a new symposium organization body, the ICM, believed in the initiative and agreed to share part of the economic risks. Many of the previous organizers and pioneers of the ISPS answered positively: Yrjö Alanen, David Rubinstein, Jarl Jørstad, Endre Ugelstad, Lyman Wynne, Stephen Fleck, Ira Levine. Only Christian Müller withdraw his participation after a first acceptance.

The decision not to restrict admission introduced the problem: how many and where? We hoped to attract a high attendance of young doctors through the choice of themes and speakers, but we had to consider the lack of knowledge of English in Italy. Thus it was important to provide *simultaneous translation* from in order to reach an attendance of more than four hundred people, an attendance able to cover the expenses of forty-sixty invited speakers, bearing in mind that young professionals were unlikely to be able to pay a high symposium fee.

The impossibility to foresee the number of participants led us to make some “blind” decisions; one of these was the symposium facility. At this time the FIAT Company was studying the destiny of its most important former factory, more than 500,000 square meters⁷ and rented out in this “ghost factory” the “sala delle alte presse” where the vehicle parts were pressed in the shape, an immense bare expanse in reinforced concrete with a huge number of columns like a post-industrial Cathedral of Granada - on the ceiling remains of rails used for moving pieces received from the nearby blast furnaces and on the floor the marks of fifty years of car production.

Positive answers were far more frequent than negative ones from all over Europe; from the Nordic universities of Umeå in Sweden and Turku in Finland to Beersheba in Israel or Double Bay in Australia, as well as from the two coasts of the United States. Most of the principal schools and therapeutic approaches to schizophrenia were represented. Already from the acceptances

⁶ Let me remember Maria Gabriella Garis, Massimo Rosa and young students such as Rocco L. Picci, Gabriele Ruo Roch who are all still important members of the department staff.

⁷ Today it has been transformed into a 5 star hotel and into a symposium center with a music auditorium for more than 1600 spectators. The hall has become an exhibition center which hosts international events like Car Show and the Book Fair.

of speakers and from first call answers it was possible to draw a sort of intellectual map of psychological therapies for severe mental illness, even if the language barrier and some economic reasons may have discouraged a higher participation from Francophone and Ibero Hispanic countries. In any case we received enrolments from twenty countries, even if the majority from abroad came from the Nordic and Anglo-Saxon world. A gratifying surprise was the participation from East Germany of the prestigious Humboldt University.

The programme rationale consisted of alternating local and foreign work groups in the same session, thanks to the simultaneous translation, in order to enhance the discussion and reciprocal exchange and to leave the plenary sessions to the most representative speakers of the different schools. In fact, a first call for attendance gave us the surprise of 450 positive answers asking for more information and the number of foreign speakers rapidly overtook the one hundred mark.

From Italy we received more than three hundred abstracts and more than a hundred and fifty from abroad; I personally decided to accept all of them even if with a little difference, dividing the Italian proposals into papers accepted and free communications. The first papers were presented with simultaneous translations as were all the foreign papers. It was a considerable effort to provide the translation for all the presentations of participants from other countries; it seemed worth providing a full presentation of what came from foreign colleagues, considering what has been explained above about the Italian situation.

There were some last minute phone calls on the eve of the symposium from Italian colleagues who apologized for not being able to attend Turin; on the contrary, there were many others who wanted to confirm enthusiastically their presence, implying that they were not sensitive to external pressure or even light threats. Leaving aside personal reservations, the Turin Psychiatric Institute was against the psychodynamic school. Moreover the recent inauguration of a university community oriented psychiatric facility at the San Luigi Hospital, able to host such an important international event, was badly accepted by part of the Italian psychiatric establishment.⁸

⁸ Same resistances I had to face with, when I was charged to close the greatest mental hospital in Collegno-Turin.

This was one of the reasons that I insisted on the ICM maintaining the participation fee as low as possible; a request that proved, in the end, to be incorrect and the budget of the symposium closed with an economic loss.

Fortunately, right from the opening, the attendance of new participants was good and, “against all odds”, in the end the foreign attendance reached 400, including speakers, and the total over 1300, including 200 invited speakers and 300 free communications. The only decorations in the immense hall were two five meter high cypress trees, kindly provided by a florist friend of my family. Nevertheless the symposium venue, as modern industrial archaeology, impressed the foreign guests and received their compliments.

The Presentations

The title of the symposium “The Psychotherapy of Schizophrenia: Approaches to Psychosis: from the One-to-One Laboratory to the Psychosocial Models” aimed to follow the traditions of the previous symposia as a continuous revision of the research and practices of the different psychotherapies of schizophrenias: individual, family, systemic and group, but gathering together the social and anthropological points of view, as the introduction to the book by *Gaetano Benedetti* and *myself* pointed out: “successful treatment might be more possible in situations where a combination of approaches is used, bearing in mind that schizophrenia has many origins and many forms and might even be many different illnesses.” Thus four fields were privileged: Theoretical Problems of Schizophrenia, Individual Psychotherapies and Clinical Approaches, Family and Group Treatments and Hospital, Institutional and Milieu Treatment, considering pharmacological intervention as transversal, but nevertheless emphasizing that schizophrenia cannot be treated by only a single approach, and also that schizophrenia is such a complex situation that it cannot be confined within the simple boundaries of the term “illness.” The main papers were each followed with a comment by an Italian expert.

Benedetti also underlined that schizophrenia is not only a medical disorder but a biographical facet of human beings and it is a challenge to the whole of society to understand, accept and reintegrate the psychotic patient amongst us, even if he was only able to dedicate himself to a single aspect: the “dyadic,” individual, therapy. Nevertheless he identified the “therapeutic transforming images” deriving from the therapist’s capacity to identify

himself with the catastrophes occurring within the patient. In this way the psychotherapy becomes progressive and the psychotherapist's discovery of this "progressive psychopathology" is the meaningful continuation of the "regressive psychopathology" studied by Bleuler, Schneider and Kretschmer.

Barbro Sandin, representing the University of Uppsala, Sweden, described the schizophrenic's paradox: "he or she who is no one. Someone is and expresses his or her being in words of non-being." *Peter Giovacchini*, from Chicago, U.S., described the treatment issues of the fact that schizophrenics seem to be operating at primitive levels that antedate the establishment of coherent object relations and they do not perceive themselves as autonomous human beings; often they do not feel human. *Adolfo Pazzagli*, from Florence, a pioneer of the psychoanalytical approach in Italy, answered the Giovacchini paper establishing a clear-cut difference between the manner of functioning which characterizes transitional space described by Winnicott and the functioning of the schizophrenic in his or her relationship with inner and outer reality, which remind us of "transitional space", which, however, is missing in the psychotic crisis, different from a transitional area.

The key papers were not only on individual psychotherapy. *Paul Watzlawick*, from Palo Alto and Stanford, U.S., starting from the Albert Einstein statement that "It is the theory that decides what we can observe" and citing an old paper by Falret and Lasègue, established the theoretical bases of the systemic therapy, based primarily on what goes on between individuals, and on how the family system and the wider community contribute to the maintenance and exacerbation of the pathological condition through their beliefs, attitudes and, above all, their supposed help. He stated that, as clinicians, we are not also trained in epistemology and may thus be quite unaware of the fact that in naming something "schizophrenic" we are doing very much the same: taking a name for the thing named, i.e. creating a reification. And depending on the nature of this reification, treatment methods based on it will have different results from those based on another reification. It was *Romolo Rossi*, from Genoa, Italy, the discussant, who pointed out that our theoretical models of interpersonal functioning of schizophrenia are, in a sense, fictions pertaining more to narrative methods than historical or scientific proceedings, partly because our knowledge of schizophrenia is decidedly clinically parasitic, and it derives only from clinical experience.

Theodore Lidz, from Yale University, U.S., pursued the concept that the intrapsychic chaos, that we term schizophrenia, derives from and reflects the chaos-inducing family environments in which these patients have been brought up and thus the need to refocus attention on the psychosocial nature of the disorder and the central role of the family. In this way he established a scientific link with *Pekka Tienari*, from Oulu, Finland, another main speaker, and his research on adoptive children with or without genetic predisposition, referring strongly to an interaction between the effects of genetic vulnerability and family environment (however, with a need for further research on manifest disorders in very disturbed families). *Bertram Karon*, of Michigan State University, U.S.A., also stressed the importance of the family and the father figure in the formation of delusions, asking himself how to transform the transference into a therapeutic instrument from a non useful defense. *Arnaldo Ballerini*, from Florence, Italy, in an ideal continuation of Karon's paper, stressed the importance of depressive feelings in the formation of delusion and as countertransference, contributing to the birth of a psychotherapeutic process. *Murray Jackson* of the Maudsley Hospital in London, U.K., described from a Melanie Kleinian point of view the "Schizoid Mental States," paying particular attention to the fear of emotional closeness to objects, deriving from unconscious fantasies of a pre-Oedipal (or early Oedipal nature, in Kleinian theory), in the attempt to achieve a deeper understanding, beyond the more familiar psychoanalytical concepts "which are adequate and appropriate for the neurotic patient but insufficient for the psychotic." From the far Australia, *Joan Symington* also looked at the early phases, but using the infant observation, observing over and over again the ubiquity of the post partum depressed state of the mother which follows a transitory state of euphoria. Her lecture was positively accepted by *Adriana Guareschi Cazzullo* from Milan, one of the Italian founders of infant psychiatry, who still pointed out the difference of some childhood psychoses from schizophrenia, while *Irene Matthis* from Umeå, Sweden, quoting Aristotle's Nicomachean Ethics, introduced an important - even if (in my opinion) open to discussion - principle that doctors cannot decide to heal a patient or make him or her healthier; the doctor's decision does not concern the goal or the aim, but only the road, the method to be chosen. Of course her provocative statement, philosophically well sustained, arose from a personal conception of the therapeutic unconscious. The individual perspective was closed by a theme whose importance was, in those days, underestimated: a project for the insurance coverage of schizophrenia by *Massimo Moscarelli* from Milan.

The clinical approaches were treated by many speakers. *John Kafka*, from Washington, U.S.A., put forward his theory that the “abnormality” is in the object rather than in the thought process proper; “insight” for psychotic patients involves insight into the characteristics of their object formation. *John Gunderson*, from Cambridge, Mass., U.S.A., presented the results of the important Boston Psychotherapy Study with Schizophrenic Patients, previously exposed in the 1981 Heidelberg Symposium, designed to provide a more rigorous test of whether a dynamically based psychotherapy (exploratory insight oriented-EIO) added appreciably to the benefits of the usual supportive treatment (reality-adaptive supportive-RAS) of schizophrenic patients. Among many other important results, RAS may help the patients feel better but unlikely to affect some of the more persistent negative symptoms. EIO, especially if directed to the out-of-therapy relationships, can have very beneficial effects upon the more negative symptoms of schizophrenia. It suggests an important role for dynamically informed exploratory psychotherapy, a role which is not apparent (or may even be contraindicated) at the start of the long-term therapeutic process schizophrenic patients usually require.

Another study, based on a large sample of individual psychotherapies, a hundred, treated by the *Benedetti group* in Milan, Italy, under his supervision was made and presented by *myself*. The aim of this research was to better understand the relationship between psychoanalytical theory and therapeutic factors. One of the many other methods used in this research was to compare the results of psychotherapies held in the public sector and those in other groups followed by therapists in private practice. Many suggestions to obtain a better recovery came from this comparison, such as communication of therapists’ feelings, involvement of families, deep observation of different individual feelings of the therapist and their “synchronisation” with the patients’ feelings, different dosages of neuroleptics, significantly lower in private practice with better symptomatic results. Even if in the public sector we could observe less good results, the more the clinical situation was severe the better the results reached. Probably a more sympathetic approach by the therapist is limited by the parameters and difficulties of the public setting. From the research it emerged that patients’ feelings change during the course of the therapy while recalls, as memory contents, never change, a dynamic which may help in the understanding of early conditioning factors in schizophrenia. In conclusion this research on severe schizophrenic patients tried to demonstrate that the psychotherapy of schizophrenia does help patients but

depends on a strong relationship between therapist's feelings and the setting⁹. Many of these statements were confirmed and developed by in-depth studies of clinical cases such as those by: *Bent Rosenbaum* from the Danish Schizophrenia Study, *Stavros Mentzos* from Frankfurt a.M., Germany, *David Feinsilver* from the Chestnut Lodge Sanatorium, Maryland, U.S.A., *Michael Selzer* from Cornell University, New York, U.S.A., *Arno Gruen* representing the Therapeia Foundation in Helsinki, Finland, *Giangiacomo Rovera* from Turin - especially clarifying problems connected with schizo-affective disorders -, *Joachim Küchenhoff* and *Peter Warsitz* from Heidelberg, Germany, *David Anderegg* from the Austen Riggs Center, Mass., U.S. Training and supervision were dealt with by *Per Stenfelt*, *Sonja Levander*, *Anders Berge* and *Michael Selzer* (Karolinska Institute, Stockholm, Sweden) and *Ann-Louise S. Silver* (Chestnut Lodge, Maryland, U.S.A.).

Family and group treatment were the object of particular attention and introduced by *Lyman C. Wynne* (Rochester, N.Y., U.S.A.) who exposed his thirty-four years of experience, starting from his first approaches to the patients' whole families when he engaged them in a task that had a psychoanalytic form: to notice their thoughts and to put them into words. This early approach was too neutral and exploratory and contributed to confirm the families' worst fears of being blamed. Furthermore the healthy, compensatory coping and adaptative potentials of these families were greatly underestimated, and sometimes iatrogenically undermined. For that reason Wynne has increasingly adopted the role of family and patient consultant rather than of therapist, discovering how effective and competent many of these families become in the face of multifaceted, difficult problems for which there are no easy answers. Wynne stated that his approach has much in common with "psychoeducational family therapy," however, without a treatment contract. Wynne was also co-researcher of the Finnish Adoptive Family Study of Schizophrenia, presented by *Pekka Tienari* and his group from Oulu, Finland. Unlike the previous genetically oriented Danish-American adoptive research, in Tienari's project also the important environmental family factors in schizophrenia and schizophrenia-spectrum disorders are studied. Still,

⁹ The further development of this research, with some others presented during the Turin symposium were published in the prestigious Yale Bulletin under the supervision of Stephen Fleck

also the Finnish data suggest that psychotic illness occurs in adoptees primarily when a genetic factor, indexed by schizophrenia of the biological mother, and disturbances in the adoptive family are both present. Thus the concept of genetic and biological vulnerability is compatible and can be integrated with psychosocial approaches. *Mara Selvini Palazzoli*, from Milan, Italy, re-proposed the pattern of the disturbed family and the contribution of her new methodology: from the previous so-called paradoxical interventions in favour of an invariable series of prescriptions, which has permitted her to identify many individual reactions and to underline some transgenerational strategies, the early disturbed relationship of the parent couple, a “stalemate of the couple,” which is connected with the children disturbance’s and could be considered the key point of her work. *Stephen Fleck* from Yale University in New Haven, Conn., U.S.A.), one of the hosts of the previous symposium, traced a psycho- and socio-dynamic parallel between families and Mental Health Services with a conclusion particularly welcomed by Italian professionals: mental health services must practice as teams and their task and system dynamics are comparable to those of families. The Italians *Piero De Giacomo*, *Giordano Invernizzi*, *Alberto Merini*, *Carmine Munizza*, *Giorgio Bisacco* (Bari, Milan, Bologna and Turin) developed from an Italian point of view many of the above mentioned family-patient-service relationships, demonstrating a good application of psychodynamic theory in the daily practice during the transitional period of the closure of the mental health hospitals.

Yrjö Alanen and collaborators, from Turku, Finland, one of the universities most involved in the psychological treatment of schizophrenias, presented further experiences in the twenty year old Turku project, centred on need-specific treatments of schizophrenic patients, considering that it is not recommended to treat all patients with the same psychotherapeutic method. This means that treatment must be conceived as an interactional developmental event and it is helpful to continuously assess the course and outcome of the treatment, which involves the possibility of modifying therapeutic plans. The starting point is represented by a first joint meeting with all the family members, successfully arranged in 87 % of the cases. The family members and (sometimes) other individuals close to the patient are invited to commit to the exploration of the situation and treatment while they are themselves given therapeutic support. The therapeutic approach has to be planned and implemented integratively, combining therapeutic activities in a manner that meets the needs of each patient as well as those of the people making up his or her personal interactional network.

Examination and treatment are dominated by a psychotherapeutic approach and different therapeutic activities should support and not impair each other, avoiding any degeneration into routine, bearing in mind that the whole therapy is an ongoing process. *Gisela Ehle* from the Humboldt University of Berlin (DDR) gave us a look from the east side of the iron curtain (we were just before the wall's destruction). The approach was primarily behavioural, but it was extremely clear that many psychodynamic concepts were implied, such as ambivalence, defences, transference and countertransference. The conclusion was that psychotherapy can help pharmacological compliance and can stimulate self-help activities. *Franz Schwarz* and *Johan De Rijke* from the Munich University (Germany) pointed out that, except for the above mentioned work by Alanen, there were hardly any results from differentiated studies from which psychodynamic knowledge can be drawn. Therefore they presented a study of 94 patients selected from 238 schizophrenic or psycho-affective patients treated psychotherapeutically, of whom the entire course of life history was carefully examined. A symptom catalogue of 180 items at the start of therapy and after follow up was developed. The change was impressive, especially in schizophrenics and in the area of sexuality and partnership. Thus, the authors concluded that a structural change occurs in the ego and in the super-ego and that object relations reach a more mature level with a clear-cut gender difference, only recently treated in the literature; maybe males have extreme difficulties in the development of gender identity. Expressed Emotions were taken into consideration by *Chris Mundt* of Munich University as a useful tool for working with relatives in groups and supporting them to found self-help organizations, to acquire information on the relatives' expectations, and to establish a hierarchy of curative group factors.

A further important session was represented by "Hospital, Institutional and Milieu Treatments." *Ruth Lidz* (Yale University, U.S.) presented her experience in the care and supervision of patients treated with psychotherapy and neuroleptics and concluded with a statement which today should be considered obvious: psychotherapy cannot be effective unless the therapist or the therapeutic team believes that psychotherapy can cure or greatly ameliorate schizophrenic disorders. In Italy, twenty six years after the psychiatric reform, this statement remains necessary for the daily work in community oriented therapy. *Luc Ciompi* and his group from the Social Psychiatric University Clinic of Bern, Switzerland, presented the first results of the four year pilot project "Soteria Berne"

(following the experience of *Loren Mosher*, also speaker at the symposium), and proposing an integrative biological-psychosocial evolutionary model available for the great majority of schizophrenics. The sensory-motor structures, Piaget's "schemata," because they are generated through actions and interpersonal transactions, represent a kind of "condensation" of social and family dynamics. There are three phases in the development of schizophrenia. First, a vulnerable premorbid terrain characterized by specific defects in information-processing, with a tendency to cognitive over-inclusion and emotional oversensitivity. Then, under the influence of additional stressors, the outbreak of manifest psychosis takes place. The third phase is the long-term evolution which is much more variable. Ciompi and Müller had presented eight evolutionary curves, most of which do not have a significant biological or genetic correlation. On the contrary, psychosocial factors may have more importance and, at least partially, chronicity may even represent a psychosocial artefact. Thus one of the most important principles for therapy and prevention should consist in trying to avoid overloads of confusing stimuli, especially in the form of cognitive-emotional contradictions and conflicts. Eight principles were selected as the main therapeutic guidelines, summarized in here: small, transparent supportive setting; protection from stimuli and close human support; personal and conceptual continuity; no medication strategies; collaboration with family and partners; clear and identical information for everybody; induction of realistic expectations; systematic follow-up and relapse-prevention. Consequently "Soteria Berne" is a small and open therapeutic community located in a very normal-looking nice former hotel building; the treatment is divided into three phases taking place within the community and one outside: the calming down, the phase of activation after two weeks, a gradual reintegration into normal life; the fourth phase begins with discharge and lasts for a minimum of two years. The results were favourable or rather favourable in 66 %, permitting a much better integration of the frightful psychotic experience into the patient's life-continuity and personal identity than the usual treatment. A further contribution from Turku came from *Jukka Aaltonen* and *Viljo Rökköläinen*, presenting and integrating systemic and psychoanalytic approaches to schizophrenia in a psychiatric ward in a facility which did not have any psychodynamic tradition, and thus demonstrating with many theoretical and technical contributions how the setting can be developed to a community suitable for psychodynamic interventions.

Attention on the psychiatric ward represented also the core of the paper by *Thomas Herzog* from the University of Freiburg, Germany. The attention is centred on the great variation between different nurse relationships, as well as between three different wards, an unfavourable milieu for many patients. Nursing staff lack the opportunity to openly discuss their emotional reactions towards patients and their relatives. Letting nurses actively participate in family or relative groups allows overcritical or rejecting attitudes to be challenged, a practice widespread in the community therapy system in Italy, as emerged in a very rich discussion and after a paper by *Teresa Corsi Piacentini* (Association for Psychoanalytic research, Milan) on training work in a public mental health service, where this participation was underlined. The Italians *Vittorio Volterra* (Bologna), and *Alberto Giannelli* and *Massimo Rabboni* (Milan) presented comparative research between different groups of schizophrenics and there were another 130 authors whose interesting research and experiences our limited space does not allow us to summarise here. At this point it is worth noting that, on the one hand, a generally correct methodology used to approach schizophrenic syndromes and, on the other, an abandonment of the psychoanalytical rigidity of the technical indications were characteristic to this symposium, compared with those from the 1950s and 1960s.

Soon after the symposium we started looking for a publisher of the proceedings book. This proved more difficult than we had anticipated. The publishers we approached were unwilling to take on the project through fear of poor post-symposium sales. Finally Hogrefe & Huber Publishers and their scientific editor, Dr. Peter Stehlein, agreed to publish on condition that certain selection procedures were followed and that a subject index was included. An indispensable help was provided by a proof reader Mrs. Kathleen Lindquist and, from the first moment of the organisation, Dr. Martin Solly. The book *The Psychotherapy of Schizophrenia. Effective Clinical Approaches – Controversies, Critiques & Recommendations*, over four hundred pages long, was edited by *Gaetano Benedetti* and *Pier Maria Furlan* and printed by Hogrefe & Huber publishers in the USA in 1993 in a handsome hard bound edition.

The satisfaction with the symposium was general despite unpredictable but easily solved daily problems. The food served at the symposium was considered good and many participants also walked round the two kilometres motor car circuit on the roof, enjoying the panoramic view of our Alps, Monte

Bianco, Monviso, Monte Rosa and Il Cervino, better known as the Matterhorn, which were also seen from the country house of the family of my dear wife, Mariella, in the courtyard of which the final dinner for the speaker was served.

Afterthoughts

Unfortunately, this period only lasted for a few years. The complex process of deinstitutionalisation, the introduction of community based system made practitioners and nurses so busy that they had to delay personal psychodynamic training or to choose the easier option of behavioural training. Even if we cannot consider them as primary causes, some facts linked with the symposium almost certainly had an impact.

The publication due to lack of funding only in English of the proceedings, rendered them inaccessible to many colleagues. Furthermore, the lack of interest by most of the Universities in Italy in Community Psychiatry led to other consequences, such as: the failure to establish a wide-reaching network of committed people and institutions after the Symposium.

No formal post congress follow-up study was made, however my impressions are the following.

The high participation of experts from all over the world encourages mental health staff to treat severe pathology and not just provide assistance. However, there was a decline in the previous enthusiasm for the changing of the mental health system linked to the closure of the mental hospitals. The more chronic pathologies still remained in the latter and therefore untreated, becoming a new challenge for young psychiatrists. In many districts the request for psychotherapeutic training increased markedly as well as did the number of private psychodynamic schools.

Thus, my staff and I could only carry through personal initiatives in addition to our ongoing work.

Nevertheless, the whole experience of the Symposium and the cultural climate it created was extremely beneficial for our closure of the largest Italian Mental Health Hospital in Collegno and the start of the restoration of the splendid Royal Chartreuse of Turin.

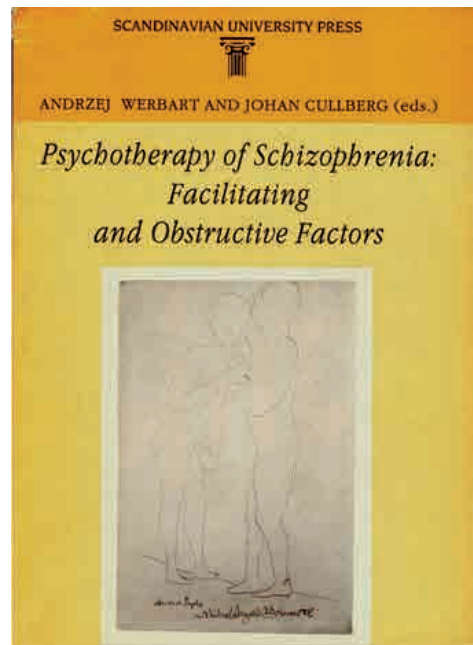
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*Book of ISPS X Symposium
Stockholm 1991*

CHAPT. 10 PHOTOGRAPHS



*Loren Mosher and the host
Johan Cullberg,
Stockholm*

*Xth International Symposium for
The Psychotherapy of Schizophrenia*
STOCKHOLM, SWEDEN, AUGUST 11—15, 1991



Program of X Symposium of Stockholm

10. The Xth ISPS Symposium In Stockholm, Sweden, in August 11-15 1991

Facilitating and obstructive factors in the psychotherapy of schizophrenia

Johan Cullberg

The process of Stockholm being elected to hosting the symposium

During the 9th symposium in Turin 1988, the Swedish group was informally approached by *Bjørn Østberg* and *Endre Ugelstad* from Norway. Would we be prepared to take the responsibility for the next symposium? At that time we were happily ignorant about the internal political tensions in the ISPS. After a brief discussion we accepted to arrange the symposium in Stockholm in case the suggestion was accepted by the board. Because of my academic affiliations I would serve as the chairman. In order to accept such a position I needed the “guarantee” to have a group of highly competent people around me, who were prepared to assist with time, advice and work. The suggestion was greeted with enthusiasm in the Swedish group.

The next step was a discussion with *John Gunderson* of the ISPS board. Since I was rather unknown to the board, John was eager to hear about my ideological position and how I, in case of being elected, would arrange the conference, which boundaries and topics we would promote etc. I informed him that to my mind all kinds of functional psychoses should be included in such a conference. Personality disorders, on the other hand, should not be given priority. I also was eager to present my interest in a broad approach including biological, psychological and social aspects as pathogenetic as well as curative factors. The symposium to the Swedish group thus would imply a dialogue between the different professional arenas with the person with schizophrenia in the centre. Gunderson’s report to the ISPS committee resulted in an official declaration at the end of the Turin meeting that I would be responsible for the next symposium in Stockholm.

The preparatory process

We had three years to prepare the symposium. The working group consisted of *Sonja Levander* PhD, *Andrzej Werbart* PhD, *Olle Lönnerberg* MD, *Margareta Falk* MD, *Irene Matthis* MD, *Inga Mellström* (secretary) and myself. We had regular contacts by letter with the international ISPS advisory group.

The practical details were taken care of by the Stockholm Convention Bureau. I took on the responsibility to find the financial support needed. The Stockholm City and the Ministry of Social Welfare showed generous interest and we soon felt that the immediate financial problems would be solved. Perhaps it should be remembered that the issues of psychological understanding of schizophrenia and other psychiatric disorders was very popular during those years in Sweden, also in political circles. There had been an ongoing tension between a psychodynamic and a biological camp. During the eighties the dynamic camp was the most cherished in media, so getting money for this purpose was not very difficult. (Today the “ideological” situation has been totally reversed.) Economically we had a “break-even” with around 450 attendants paying the fee and the actual number showed to be almost 700 including invited participants.

One of our first tasks was to define the central theme of the conference. We arrived at the following formulation: “Facilitating and obstructive factors in the psychotherapy of Schizophrenia” and it was accepted by the international advisory board. We felt privileged to be able to put conflicting themes and points of view to the fore. Of course one of the hottest issues was the negative results from the McGlashan study (1984) of the long-time schizophrenic patients treated at the psychoanalytical stronghold at Chestnut Lodge. Also the studies of Gunderson (1984) and Wallerstein (1986) had shown supportive psychotherapy as effective as explorative psychotherapy. These findings contributed to an acute identity crisis of the ISPS ideas – denied by some and leading to a total break with the psychotherapy of psychoses by others.

Another issue which we wanted to pick up was the advancement of cognitive-behavioural and educational methods during the eighties. There was a mutual devaluation between the psychodynamic and the CBT camp, the patients being the losers. The possibility to offer the proponents of the different schools an opportunity to listen to each other seemed important, even if it meant a serious challenge to some of the ISPS people.

A third issue was to emphasize the self-curing factors in long-term schizophrenic persons. Here Harding's (1987) studies were seminal indicating the amelioration in outcome several decades after the first diagnosis for patients who were not institutionalised. Were optimal social conditions a precondition for being able to make use of psychological treatments?

We felt that our central themes would cast light upon the different ways of assisting versus disturbing the important self-healing facilities in the person with schizophrenia. Our main interest was to put the suffering person in focus more than certain theories or methods.

The making of the programme

I will not go into any detail about the contents of the different contributions – some of the most important ones are presented in the congress report, a book published by *Andrzej Werbart & Johan Cullberg (1992)*. The first lecturer to be invited was *John Strauss* who was asked to hold the opening lecture on "The person with schizophrenia as a person". Then the ISPS members were invited to present papers and a general message announcing the conference was sent to different international groups within the area of psychology and psychiatry. We formed an abstract paper group to set some basic standards for the quality of the scientific contributions. In a few cases we had to turn down abstracts that had been submitted, others were accepted after a discussion.

A historical lecture was held by the legendary professor *Gaetano Benedetti*, one of the pioneers of the ISPS, where he briefly characterised the previous symposia and some of the contributors.

The contributions were divided into different blocks. Discussants were designed to all invited lecturers, which gave increased possibilities for critical reflection.

One block named The inner world that was comprised by mainly psychoanalytic lecturers. Most of them had a clinical approach: *Murray Jackson* on schizoid thinking, *Barbro Sandin* on schizophrenic strategies for survival, and *Bryce Boyer* on regression in transference. Also the French semiotic psychoanalytic thinking was represented by the Nordic contributors *Irène Matthis*, *Svein Haugsgjerd* and *Bent Rosenbaum*.

The second block, Psychotherapeutic models, was mainly devoted to the presentation of new and promising pathways. *Luc Ciompi* talked about the Swiss “Soteria project” for first episode schizophrenia patients. *Manuel González de Chavéz Menéndez* (chairman of the present Madrid conference) described group therapy experiences with schizophrenic patients and *Carlo Perris* and *David Fowler* talked about cognitive psychotherapy for this group of patients.

One block was devoted to Biological and Psychosocial factors. Here *Pekka Tienari* described the latest results from his seminal project studying the interactions between genetical and rearing environmental factors. *Stephen Fleck* gave a synthesising lecture on the biological and psycho-social factors. Family as a social milieu was highlighted by *Michael Goldstein’s* research, and *Helm Stierlin* reconsidered the role of the family from theoretical and practical points of view. Social context was also accentuated in *Yrjö Alanen’s* lecture on psychotherapy of schizophrenia in community psychiatry. *Loren Mosher* talked about treating psychotic persons in a therapeutic social milieu.

Anne Lindhardt from Denmark and *Per Vaglum* from Norway were invited to give personal reviews of the Symposium during the last day and also gave hints about the future of the psychotherapy of schizophrenia. *Per* stressed that today’s many negative findings regarding effects of psychotherapy often may depend on the comparison of group means, meaning that positive and negative effects are neutralising each other in the research situation. He also pleaded for the necessity to be open to new techniques and to new facts which perhaps not always fit into our theoretical models. *Anne’s* thoughtful reflections dealt with the complexity of the schizophrenia concept and of the necessity of broadening our views so that also man as a biological person can be included. The therapist’s curiosity is a basic factor for increasing our knowledge and therapeutic courage. She also discussed the gender issue; male patients often tend to have a worse outcome in therapy than females. And how shall we interpret the surplus of women amongst the audience and among the therapists? Finally: our obligations to present our issues in a way that gives meaning and understanding also to “outsiders” like politicians and other lay people must not be forgotten!

In addition of these lectures there was an abundance of seminars and workshops where several researchers and therapists who would appear at later conferences presented their first paper.

The setting

Stockholm kindly enough appeared at it's best; bright sun, mild winds and the Stockholm Water Festival going on during late evenings. At the opening ceremony, after the deep tones of an ancient bassoon, the Swedish Deputy Prime Minister *Odd Engström* gave an insightful address to the Symposium delegates.

The magnificent festival firework on the waters outside the Royal Opera Restaurant happily coincided with the farewell party when Stephen Fleck generously at his dinner speech told us that this had been the "best congress." Almost 700 delegates would return to the outside world with a realistic hope for an international development of the psychotherapy of schizophrenia.

The economic surplus was partly used to sponsor a National conference in Sweden, which was the beginning of the later "Parachute project" for first episode psychotic patients. The rest of was sent to *David Feinsilver* to support the 11th conference in Washington DC, which also included a visit to the historical Chestnut Lodge.

Afterthoughts

This conference probably meant that the great dominance of psychoanalytic theory and ideology was broken and that new ways of looking to the problems were approaching – not necessarily as competing with the old ways but refreshing and stimulating new experiences. I also believe in the necessity to have a diagnostically open mind. The validity of the schizophrenias is not too well defined and the psychosis concept must continue to be more central than the schizophrenia concept.

And we must not forget Per Vaglum's nightmare: That the patients are given very good individual or family therapy, but since they live in a destructive institutional or social milieu, the good effects of psychotherapy are destroyed by the environment. Be that large psychiatric wards, isolation in a lonely flat, or being subjected to overmedication. That must be another important challenge for the ISPS: to help us create such milieus which are really therapeutic and to continue to show our interest in the therapeutic use even of the biological treatment methods. After all, we are treating a person, not a bunch of receptors.

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*David Feinsilver
Chairman of Washington Symposium*



*Yrjö Alanen receiving
ISPS honorary gift*

CHAPT. 11 PHOTOGRAPHS



*Endre Ugelstad receiving
ISPS Honorary gift*



*Stephen Fleck
receiving ISPS
Honorary gift*



*Jack Rosberg and
Bent Rosenbaum*



*Llan Treves and
David Feinsilver*

CHAPT. 11 PHOTOGRAPHS



*Malcolm Pines, Dianne Lefevre
and Murray Jackson*



*Opening Ceremony of
Washington Symposium*



Ruth and Theodore Lidz



Stanley Possick

CHAPT. 11 PHOTOGRAPHS



*D. Feinsilver during gala
dinner of Washington
Symposium ISPS*

11. The XIth ISPS Symposium June 12.-16.1994 in Washington, DC, U.S.A.

Schizophrenia: Psychotherapy and Comprehensive Treatment

Stanley Possick and Ann-Louise S. Silver

The symposium, "Schizophrenia: Psychotherapy and Comprehensive Treatment" was held in Washington, DC at the Washington Renaissance Hotel, June 12-16, 1994. About 480 people attended this rich, festive and lively meeting. *David Feinsilver*, MD, chair of this event said this meeting would "focus on integrating recent divergent trends in understanding the biological, psychological and social dimensions of treatment." The meeting's international board consisted of seventeen leaders of our field: Drs. Alanen, Ciompi, Cullberg, Feinsilver, Furlan, Gunderson, Leff, Levine, Orwid, Østberg, Possick, Rosenbaum, Schwartz, Stierlin, Tienari, Ugelstad, and Wynne. The Chestnut Lodge organizing committee included Drs. Bullard, Jr., Cohen, Goodrich, Fenton, Heinssen, Israel, Rieger, Silver, Waugaman, along with A. Tolins, ATR. The U.S. Organizing committee included many of these people along with Drs. Boyer, Carpenter, Gabbard, Gibson, Goldstein, Gunderson, Hogarty, Keith, Kernberg, Liberman, Mosher, Munich, Rabinowitz, Scharff, Schulz, Selzer, Sharfstein, Steinman, and Volkan. Honorary members included Drs. Benedetti, Fleck, Jørstad, Lidz and Müller. Susan B. Miller served nobly as the administrative secretary/treasurer.

Setting and Program

Almost all of these people participated in the program in some way, guaranteeing from the outset that this would be an outstanding learning experience for all in attendance. The meeting included an opening reception at *Chestnut Lodge*, with a tour of the grounds. An international folk and American square dance party was held on the second evening.

Historically, a special meeting took place on Tuesday afternoon, to discuss the feasibility of the ISPS becoming a formal Society. A gala banquet and awards ceremony was held at the Great Hall of the National Building Museum. A beautiful glass piece with the text "Lifetime Achievement Award to ... for Outstanding Contribution to the Psychotherapy of Schizophrenia, June 15, 1994" was given to 10 pioneers: *Yrjö Alanen, Gaetano Benedetti, Bryce Boyer, Stephen Fleck, Murray Jackson, Jarl Jörstad, Theodore Lidz, Christian Müller, Endre Ugelstad and Lyman Wynne*, later regarded as the first Life Honorary Members of the ISPS.

The arrangement of the symposium received contributions from six pharmaceutical companies. One hundred and twenty speakers were invited and 140 independent paper presenters came from 22 countries. The lower-than-expected attendance was attributed to the atmosphere of demoralization among U.S. mental health workers, due to the general devastation of institutions brought about by insurance companies' managed care firms. Because of the surprisingly low turn-out, the committee was forced to ask the invited speakers to forego the promise of total reimbursement. Seventy-five percent of the speakers responded favorably. Dr. Feinsilver managed the chronic stress attendant to the organization of this meeting with great dignity and perseverance.

The program of the symposium was divided into eight main sessions, each session including a single plenary panel followed by a group of concurrent panels. These sessions were: I: Introduction to the Bio-Psycho-Social Model; II – Bio-Psycho-Social Vulnerability; III – The Biological Perspective; IV – The Psychological Perspective; V – The Social Perspective; VI – The Integrative Perspective; VII – Evaluation and Research and VIII – Directions for the Future. These sessions were held sequentially. The first consisted of a single panel, "The Integrative Perspective: An Introductory Case Presentation, given by *Michael Selzer*, co-authored with *Jonathan Krieger* who was the patient's therapist. The formal discussants were *Will Carpenter, Daniel Schwartz, and Ian Falloon*.

Session II included a plenary panel composed of *Yrjö Alanen, Luc Ciompi* and *Thomas McGlashan*, with discussion by *Michael Robbins*. As Robbins noted, McGlashan's model differed greatly from those of Alanen and Ciompi. McGlashan tried modeling the dynamic moment of hallucination, developing a hypothesis about the neural network responsible for hallucinations and drawing on evolving understandings of parallel processing computers. Robbins

ultimately concluded that McGlashan's theories found little place for psychoanalytic techniques, and little meaning in schizophrenic communication.

On three of the days, the day concluded with Small Discussion Groups, allowing participants to get input regarding the panels he or she had not attended, and to help highlight key themes. Participants were assigned to groups so there would be a mixture regarding nationality and discipline. Each small group had a chairperson who helped facilitate discussion and noted material to be presented at the closing plenary discussion. From 7 a.m. to 8:15, independent papers were presented (usually to a small gathering of earlybirds).

Papers published in the journal *Psychiatry*

While David Feinsilver expected that twelve to fifteen papers of the seventy submitted would be published in the journal *Psychiatry*, ultimately just four were published, by Alanen, Ciompi, Feinsilver and Kafka. Tape recordings had been made of the entire meeting by Goodkind-f-Sound, but these are no longer available. These four presentations were part of a series in the journal which highlighted the treatment of individuals suffering from schizophrenia. The editors were particularly interested in papers which explored various psychotherapeutic endeavors, which served as crucial components of comprehensive treatment approaches to schizophrenia. This orientation was consistent with the central theme of the Washington Symposium.

Yrjö Alanen (1997) does a masterful job of exploring both biological and psychosocial vulnerabilities, and linking them to the development and course of schizophrenic disorders. He then considers the treatment implications of his hypotheses. In this context, he discusses "Need-Adapted Treatment". In this treatment model, case specific therapeutic needs are defined – with the aid of initial "therapy meetings", participated by the patient, his/her family members and the therapeutic team – , and various modes of treatment, e.g. family-and environment-centered crisis intervention, intensive individual therapy, therapy of the primary and/or secondary family, milieu therapy, medication (preferably in low doses), are employed as indicated by clinicians. Alanen's focus on listening to, understanding, and treating all aspects of the schizophrenic individual's difficulties in an integrated way represents the equivalent of therapeutic neutrality with the schizophrenic person.

Luc Ciompi (1997) presents a complex and very sophisticated bio-psycho-social conceptualization of the development and treatment of schizophrenia. Drawing on decades of work with schizophrenia, Ciompi's model is based on affect-logic theory. "It postulates that fundamental affect states (or emotions, feelings, moods) are continuously and inseparably linked to all cognitive functioning (or "thinking" and "logic" in a broad sense), and that affects have essential organizing and integrating effects on cognition. Schizophrenia is understood as an altered mode of affective-cognitive interaction based, possibly, on disturbed (loosened) affective-cognitive connections." (p 158) Ciompi points out that his hypothesis suggests particular ways of understanding the evolution, course, and treatment of schizophrenia. Like Alanen (1997), who cites Ciompi's work, Ciompi proposes a bio-psycho-social model of the evolution of schizophrenia, in which he links neurobiologic, psychodynamic, and psychopathic phenomena. His hypothesis also leads to "a new understanding of the psychopathological core phenomena [of schizophrenia] such as ambivalence, incoherence, and emotional flattening." (p 158) It also leads to "innovative therapeutic approaches, with special emphasis on the emotional atmosphere of therapeutic settings and methods," (p 168) Finally, Ciompi's hypothesis raises the possibility that schizophrenia might be an affective disorder.

In an elegant clinical paper, *David Feinsilver (1997)* hypothesizes that the therapist's counteridentifications with that which is frustrating his or her schizophrenic patients at moments of great urgency for the patient, lies at the very heart of what is mutative in the psychotherapy of schizophrenic patients. The therapist's awareness of his or her own countertransferences to the schizophrenic person, and the material being presented, clarifies the therapist's counteridentifications with the patient. This allows the therapist to work in a more integrative way with the patient. Feinsilver says that the therapist may "make focally targeted interventions that integrate supportive and interpretive aspects of the comprehensive bio-psycho-social treatment that such severely ill patients require." (p 260) The therapist's capacity to be aware of and integrate fragmenting tendencies within himself, in identification with the patient's doing so, helps schizophrenic patients to "integrate such fragmenting tendencies within themselves." (p 248) He argues against the tendency "to see one aspect of the patient's problems as the "be-all-end-all answer" to the exclusion of all others." (p 248) In this sense Feinsilver's ideas and therapeutic approach are quite consistent with Alanen's.

John S. Kafka (1997), a psychoanalyst working at Chestnut Lodge, has written a complex and rich paper, in which he describes the evolution of his views about the nature and treatment of schizophrenia. He elucidates the process of an inner journey, the result of which is Kafka's integration of a longstanding and deeply felt humanistic ("romantic", psychodynamic) approach to schizophrenic individuals with more recent neurophysiological data and his own insights about the nature of schizophrenic objects and their link to thought disorders ("classical" approach). Kafka also considers and describes the clinical implications of his hypotheses. He builds bridges between seemingly incompatible ways of conceptualizing and treating schizophrenia (making contact with another person versus treating a generally describable disorder). The process he describes is a very personal one, but Kafka also captures the nature of the internal struggles with which so many of the participants at the Washington Symposium grappled.

In the first section of his paper, Kafka explains what he means by classic and romantic visions in the conceptualization and treatment of schizophrenia. This is followed by a brief historical perspective on the treatment of schizophrenic people at Chestnut Lodge. He also outlines the dangers inherent in utilizing a completely "romantic" or "classical" approach to the schizophrenic. Kafka draws heavily on work by Strenger (1989) and Cohen (1994) in this section of the paper.

Kafka discusses Strenger's paper on classic and romantic visions in psychoanalysis, and he applies this model to psychodynamic psychotherapy of schizophrenia. These two visions share a common interest in the concept of autonomy, but have differing views about what autonomy is. The classical nineteenth century notion of autonomy was articulated by Hegel, who believed that each person must recognize that he is just one "aspect of the general structure of reality" (p 262), and that he must submit to the whole. Kierkegaard, who represents the romantic vision, understood autonomy in terms of the "individual's ability to attain his own subjective truth" (p 262) (Kafka quoting Strenger p 596). Kafka's clinical approach to schizophrenia was originally very consistent with a romantic notion of the patient's autonomy. This perspective had its origins in a "long-standing humanistic... tradition in psychiatry" (p 262), and it was associated with heroic efforts by dedicated clinicians.

Kafka notes that this approach was reflected in earlier clinical work with schizophrenics at Chestnut Lodge. No schizophrenic person was seen as so

different from other people that he or she was permanently inaccessible, isolated, and unresponsive. Harry Stack Sullivan's belief that the social sciences could help in making and maintaining contact with schizophrenic patients contributed to the sense of therapeutic optimism at the hospital. Kafka, citing Cohen's (1994) presentation at the Washington Symposium, notes that Sullivan influenced Frieda Fromm-Reichmann, who viewed the schizophrenic person as a participant, not simply a victim, in his or her family drama. The patient's autonomy in this conceptualization is close to the romantic view of autonomy. Fromm-Reichmann also paid close attention to the patient's responses to anxiety. Kafka notes that she became increasingly concerned with ego defenses which delayed ego development. She also believed that it was crucial to use language with the patient that communicated "to the patient that he or she was being understood." (p 263) Kafka views countertransference as "part of the romantic tradition because it emphasizes the personal" (p 263) reality of the therapist. Feinsilver's paper illustrates this beautifully.

In summary the romantic view of the schizophrenic person is highly individualistic, and it focuses on a longitudinal, i.e. developmental and life-history approach to understanding and treating the patient. In contrast, the classical vision takes a more cross-sectional approach to the patient. It focuses on a specific symptom complex at a given point in time. Kafka feels that the primary interest in the classical vision is on the general structure of reality rather than on its development. He believes that exclusive use of a "classical" perspective with the schizophrenic may lead to a type of "tunnel vision" (p 263) about the patient. The clinician utilizing only a "romantic" perspective may minimize the great differences between the workings of his or her mind and the schizophrenic's. Kafka goes on to highlight other potential problems associated with the exclusive use of either a "romantic" or "classical" view of schizophrenia. He notes Strenger's description of the psychoanalyst's internal tensions between his classical and romantic attitudes towards a given analysand. There is a constant tension between identification with one's own perspective and the need to detach from it to be able to reflect on one's self from the outside. These tensions are considerable for the psychoanalyst, who is working with non-psychotic patients. Kafka believes the tensions are far greater for the psychotherapist, who is working with psychotic patients.

Nathaniel London's work (London, 1973), regarding the differences between a unitary and a specific theory of schizophrenia helped Kafka to develop his

own specific theory about the core problem in schizophrenia. That is, London's work helped Kafka integrate his "romantic" vision of schizophrenia with a more "classic" one. Kafka moves from the struggles of the individual clinician to the hospital. He raises the following question: Can advances derived from a romantic vision be safeguarded in modern hospitals, when these hospitals are pushed in the direction of a classic vision of schizophrenia? Kafka addresses this question by describing changes in the treatment approach at Chestnut Lodge. The changes took place during the years before the Washington Symposium (1994). There is less focus on individual psychotherapy. There is an even greater emphasis on the milieu than in the past. There is an increased use of medications. Residential care, social therapies, and rehabilitation are all emphasized.

In the second part of the paper, Kafka describes his own efforts to integrate a more "classical" perspective, which includes the development of a specific theory of schizophrenia, with his long-standing "romantic" vision of schizophrenic individuals. We will not attempt to discuss Kafka's theory building or its implications for clinical technique. Suffice it to say, he is concerned with the schizophrenic's objects, which he terms "atmospheric objects", and their role as the most salient feature of the schizophrenic's thought disorder. He illustrates his beliefs with a lovely clinical example (the Heidi story, p 266). He describes the physiological evidence which supports his belief that disordered rhythms in the brain "lead to idiosyncratic schizophrenic object formation and this, in my view, is the basis of schizophrenic thought disorder" (p 267). He goes on to discuss synesthetic phenomena and déjà vu experiences. Kafka says, "My thoughts about the uncanny interpretation of synesthesia-related and temporal lobe-related déjà vu experiences form a bridge between what has been viewed conventionally as psychological and biological approaches to the phenomenology of schizophrenia" (p 268) Kafka discusses this in some detail and then, using a clinical example, illustrates its implications for clinical technique. "It is important that knowledge of cognitive defects of schizophrenics inform some aspects of the treatment, but such techniques can coexist with the romantic notion of the value of an individualized approach that requires dynamic understanding." (p 270) He uses work by Reiss to illustrate further "the marriage of classical and romantic vision." (p 270) Kafka summarizes his own integrative work as follows "For me there was, however, an evaluation, a reconciliation of perspectives. Although the atmospheric schizophrenic objects may be the result of a "deficiency," as seen from the outside, the therapist struggling to understand these idiosyncratic, not commonsense

objects, to comprehend them also from within (the patient), has a romantic vision by virtue of the intense focus on this particular inner reality of the individual. The classic outside view, the recognition of the schizophrenic “deficiency” coexists with the respectful search for the individual’s inner truth.” (p 272) The point is not whether one agrees or disagrees with Kafka’s theory of schizophrenia. Rather, it is that each of us must struggle with the types of questions he raises. Kafka’s presentation thus formed a philosophic tent within which the many presentations of this meeting found a place as illustration or elaboration.

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CHAPT. 12 PHOTOGRAPHS



The ISPS appeared under this name as such in the 12th Symposium, organized by Brian Martindale in London, in 1997, with an important participation of professionals from all the continents and interventions from all the therapeutic approaches.



**Brian Martindale,
Chairman of London Symposium**

12. The XIIth ISPS Symposium in London, October 1997

Building bridges

Brian V Martindale

Personal Background

My first ever contact with the ISPS was the 10th ISPS conference in Stockholm organised in 1991 by Johan Cullberg and his Swedish colleagues. This was a most inspiring experience. I recall being most moved by the many sophisticated accounts of a wide range of psychologically based interventions for those with psychosis given by Scandinavian colleagues. It was clear that such interventions were relatively widespread, a situation which contrasted greatly with the UK at that time, where such interventions were confined to a few services and they were regarded as somewhat unique whether analytic, cognitive behavioural or using “expressed emotion” family work. I had the impression that the professional ‘distance’ from psychotic patients was less in Scandinavia and that there was more of a cultural attitude that whatever their biology, patients had gone ‘under’ because of the slings and arrows of outrageous fortune in vulnerable persons.

In 1988 I had organised a UK conference involving leading psychotherapists from other European countries. This had played an important part in loosening my somewhat idealised island mentality about UK psychotherapy and it was here that I first met Johan Cullberg. He, together with some others, has become a most inspiring figure, colleague and friend over the subsequent years. An outcome of the 1988 UK psychotherapy conference was my contributing to the formation of a European wide Federation of Psychoanalytic

¹ EFPP –see www.efpp.org for further details

Psychotherapy organisations focussing on the Public Sector (the EFPP)¹. During the course of the Stockholm ISPS conference, I spent time together with *Murray Jackson* and *Michael Conran*, (two British psychoanalysts who had spent many decades working in the NHS with services focussing on psychosis) who had got to know of my organisational experience and contacts in Europe. They were coming towards the end of their NHS careers and had been involved in the ISPS for many years and wanted the conference to come to the UK for the first time. I took little persuasion from Murray and Michael that there could be many positive consequences for the UK and my appetite was whetted to try and make our dream come true.

Laying the foundations

I soon found that this idea - of organising a major international psychosis conference in the UK and bringing a considerable number of international experts in a wide range of psychological approaches - captured the imagination of a considerable number of people as well as the UK mental health organisations to which they belonged. There was excitement at the possibility that such a conference could make an impact on professionals and policy makers. In the late 1980s and early 1990s there was increasing disillusionment with many aspects of UK mental health services and the rather dominant biological framework in which treatment took place.

At that time, British cognitive behaviour therapists were gathering increasing clinical research evidence for the effectiveness of their interventions in psychosis; there was also frustration that the relatively few UK nurses who had trained in psychosocial interventions were not being adequately supported in carrying out this work. Also the skills of many practitioners from all core professions (including the arts therapies and social workers trained in case work) whose understandings of psychosis encompassed a psychodynamic framework often felt unappreciated and struggled to find the space to use their skills in individual, group and community settings.

¹ EFPP –see www.efpp.org for further details

I think that the ISPS board were impressed that a considerable number of a provisional planning committee came over to the 11th ISPS meeting in Washington in 1994 and presented our case together, aiming for the 12th ISPS conference to be held in the UK in 1997. It felt somewhat like a small scale bid for the psychosis Olympics! We were successful and the torch of enthusiasm was now firmly lit.

I was elected as the chairman of organising and scientific committees. We divided ourselves into two groups, one was responsible for developing the scientific programme. The other was a large group of people formally representing a whole host of UK mental health organisations whose members were involved in psychosis. This combination of two groups -one dedicated to a high class 'scientific' (or perhaps better expressed 'professionally relevant') international conference programme and the second group concerned with ensuring full publicity and support for the programme from a wide range and large number of relevant UK professionals - was certainly the key to the success of the conference in terms of UK participation. The full list of the core members of the UK scientific committee as well as supporting organisations is given in Appendix 1.

Although it will be clear how many organisations were involved it is important to highlight how important for the conference and its influence was the support of the President and several component faculties of the Royal College of Psychiatrists together with the British Psychological Society, the Royal College of Nursing and key persons within the Department of Health.

The reader will not be surprised that our conference title was BUILDING BRIDGES with all its significances in terms of organisations, modalities, disciplines, as well as the bridge building with patients and their families where there is psychosis

A major headache, and a non-pharmaceutical cure – for us at least We quickly ran into a major problem which may have been a blessing in disguise. In the early 1990's there was only one conference centre in London that would both take a 1000 or so participants and had an adequate number of rooms for the many parallel sessions we needed. We were confident that national and international attendance would be high, if we could provide plenty of opportunities for people to present on a wide range of themes relevant to psychosis. Our problem was that there was absolutely no

financial surplus from the previous ISPS conference and we could not make any of the very considerable advanced payments for the conference venue and for the production and mailing of international publicity. The ISPS was completely broke before we had started!

This was a source of enormous strain and I found myself wondering if my coronary arteries would last until 1997. As a result of an urgent foray to try and interest professional conference organisers, we were most relieved when a European wide organisation based in Brussels not only agreed to take the full financial risk of the whole conference but also were more than ready to sign a contract unconditionally offering £20,000 to our parent ISPS organisation at the end of the conference. In retrospect, I think the company may not have realised that the pharmaceutical companies would not necessarily contribute that much sponsorship to an organisation focussing on psychological interventions – but I was certainly greatly relieved that we could now concentrate on putting on the professional side of the meeting – the full financial risk and presumably a headache being ‘transferred’ to the conference company!

The Conference

For those visiting the UK, the conference setting could not have been improved on. The Houses of Parliament, Big Ben and Westminster Cathedral were fully visible just across Parliament Square through the extensive glass frontage of the Queen Elizabeth II centre.

We had close to a 1000 participants and during the course of the four and a half days there were more than 307 presentations, let alone the added contributions of invited discussants and the active participation of many of the chairpersons.

Our aims were to make available to both the leaders of mental health organisations in the UK and ‘ordinary’ mental health practitioners the knowledge and experience of a wide range of psychologically based interventions that could be of use to persons with psychosis and their families. We wanted to highlight not only what was happening in a range of other countries but also to underline how much expertise, experience and knowledge from research was available in the UK but how little this was applied.

We spent considerable time carefully selecting our invited speakers and it seems appropriate to give a very brief account of their contributions. We hope that this will not detract from memories of some 250 other speakers from many countries who, in smaller scale settings, contributed enormously to the success of the conference. In this account there is not space to describe the several social occasions and the London settings of both the Speakers and Conference Gala that contributed to the conference's success.

However an important historical event for ISPS took place during the London conference. This was the official transformation of the ISPS from an organisation that put on conferences to an international organisation that had a wider range of functions aimed at promoting and supporting those interested in the development at national and local level of psychological interventions in psychosis. This will be described in a separate chapter.

Two important pioneers of psychosis psychotherapy, professor *Helm Stierlin*, M.D., Ph.D., from Heidelberg, Germany, and *Barbro Sandin*, Ph.D., from Ludvíka, Sweden, were invited as *Life Honorary Members of the ISPS*.

Invited Speakers

It was especially important for the conference and its aims of making a long term impact in the UK that amongst other important dignitaries the conference was opened by the UK Minister of Health, Rt Hon Paul Boateng and the President of the Royal College of Psychiatrists who had been involved during the planning stages (Dame Fiona Caldicott).

There were a number of major themes that orientated each day. One day had a number of plenary presentations on British perspectives on the psychological therapies, whilst another day concentrated on the breadth of contexts within Europe for developing psychological therapies. A further pair of sessions focussed firstly on first episode psychosis and then 'chronic' psychosis. Another day focussed on the EVOLUTION of contemporary ideas about psychosis and the last day looked ahead to improvements in prevention of psychosis, optimum protection and optimum therapies for persons with psychosis

Michael Robbins (USA) gave a most challenging *opening address*. First he emphasised the fallacy of many past and current endeavours which attempted to reduce the understanding of schizophrenia to a single

theoretical framework, whether psychological or biological and he emphasised the importance of general systems theory. In surveying the range of interventions, he considered that most approaches reinforced and stabilised basic elements of the dis-ease in the individual, family and social systems (*iterative processes*). It was the exception that a therapy was aimed at actualising the potential of the individual through *mutative* processes which might therefore often inevitably involve periods of disruption and reorganisation of individual, familial and social systems. To my mind, Michael Robbins' view remains a most important consideration that needs far more attention than it receives.

A full afternoon was devoted to hearing the *experiences* of a range of UK and USA users, carers and family members as well as those of professionals. This 'experience near' event was a great success and made a big impact on many professionals. In 1997 it was relatively uncommon to have such active user and family participation in a large professional conference. For many, this was the first time they had heard in an organised way directly from users, carers and children of the mentally ill. Perhaps some of what was conveyed had more connection with what Dr. Robbins was referring to than we realised at the time.

An outstanding presentation was given by *Wayne Fenton* of the USA who managed to synthesise much of the relevant contemporary research in a way that gave considerable inspiration and support for developing the objectives of the ISPS in pursuing psychological interventions.

Family approaches

Julian Leff (UK) is one of the best known of UK schizophrenia clinicians, researchers and innovators and he focussing especially on the reduction in relapse and readmission rates when 'expressed emotion' (EE) can be lowered in families. Professor Leff was at pains to emphasise his view that expressed emotion is neither peculiar to schizophrenia, nor the reason for its onset. In considerable contrast, *Lucy Johnstone* revisited the 'taboo' subject of the role of the family in schizophrenia. She was of the view that collective avoidance of looking more closely at certain evidence leads to considerable limitations in both theories of psychosis and in the practical work and help offered to families and individuals.

Pekka Tienari (Finland) has devoted much of his professional research life to a project studying adopted away children of mothers who had schizophrenia and in so doing uniquely examining BOTH sides of the nature –nurture controversy. His research shows an interaction between the genetic factors and factors in the rearing environment. The idea of protective factors in families is inherent in this most important work. *Peter Steinglass* (USA) gave an overview of the trends in family therapy in recent decades and highlighted the promising developments of multi-family groups (MFGs) where there is psychosis and his evaluation of the effective components of MFGs.

Cognitive and Psychodynamic approaches

Max Birchwood (UK) gave a thorough overview of current theoretical underpinning of the cognitive therapy framework and its relation to the ‘self’ and ‘identity’ in psychosis and their interrelatedness with interpersonal problems and withdrawal. Birchwood’s thinking has clear connections with dynamic ideas especially in the concealed personal meaningfulness contained in psychotic ‘symptoms’. *Liz Kuipers* and *Philippa Garety* (UK) described one of the first UK studies showing the effectiveness of cognitive behaviour therapy for psychotic symptoms refractory to medication and that this improvement was maintained at follow up and they delineated the six stages of the approach.

Murray Jackson (UK) has extensive experience of supervising as a psychiatrist and psychoanalyst since retiring from the NHS. He spoke cogently about the deterioration of psychiatry in the face of market forces leading to minimalist short lasting interventions in psychosis (he emphasised that there were notable exceptions). Jackson gave a vivid account of the potential contributions of psychoanalytic thinking to psychosis services and made a plea for an ISPS charter of rights of patients with psychosis that including assessments that involved a psychodynamic interview and formulation.

In contrast to the UK situation, *Richard Munich* (USA) gave the reasons for his, perhaps (with hindsight) rather hopeful, view of the resumption of general interest in psychodynamic psychotherapy in the USA. There has been an increase in awareness that symptomatic improvement and

environmental manipulations do not correlate well with functional improvement. Also psychodynamic therapists were now adopting a much more flexible technique according to the phases of the disturbance and there was much greater preparedness of therapists to work alongside practitioners of other modalities.

Concern is increasingly expressed across nations at the increasing and very large number of psychotic patients in prison and forensic services. *Pat Gallwey* (UK) gave an enthralling account of disturbances in unconscious thought processes in those who come the way of these services.

The early phases of psychosis and the first episode

ISPS owes a great deal to the Finnish need adapted approach pioneered over more than two decades by Yrjö Alanen and his colleagues. The conference had a special session on the first episode of psychosis, an area that in 1997 was beginning to attract the interest of policy makers around the world. *Jukka Aaltonen* gave another exciting and radical Finnish presentation, describing a whole community approach in Lapland where all the mental health professionals involved are becoming fully trained in family therapy. Any call for a prodrome or psychosis situation is responded to the same day and an open dialogue process is initiated with the whole family and professionals. This radical intervention in the system has led to a marked reduction in the incidence of psychosis and in in-patient care, but a rise in the incidence of prodromal cases seen, neuroleptic usage is needed in only 30% of cases and at the time there were no new long term cases since the project started.

Johan Cullberg (Sweden) and his colleagues gave some most encouraging results from the first years of the 'Parachute' project in which many Swedish centres are participating adapting the Finnish need-adapted approach for first episode psychosis patients and *Pat McGorry* (Australia) gave an inspiring talk giving an overview on aspects of prevention in psychosis. He looked at the possibilities a) emerging from the recognition of prodromal disorders in psychosis, b) for improved outcome if phase and need specific therapies are applied according to age and stages of development especially youth orientated approaches c) from reorganisation of services to allow for such optimal and phase specific therapies, aiming also to minimise harm and trauma.

One of the most important challenges is how to translate the positive evidence from research of the effectiveness of psychological and psychosocial interventions and equip staff in regular services with the skills to implement the findings. *Tony Butterworth* (UK) gave an overview of the UK multicentre Thorne training initially for nurses, highlighting its achievements and limitations so far. The latter particularly relate to the organisational changes needed to accommodate the skills of trained persons.

Cultural Contexts

Suman Fernando (UK) gave his views that racist ideologies permeate UK psychiatry and psychology, leading to inequalities in diagnostic and therapeutic practice. He was also of the opinion that the psychological therapies, (when offered) were inappropriate to the needs of black people especially. In contrast to some other areas of society he thought that psychiatry remained mono-cultural with innovations by black and other minority groups not permeating the established systems. *Michael Stone* (USA) gave an erudite historically orientated perspective on contemporary ideas about the psychoses and how cultural factors varying with time might either disguise the existence of psychoses (e.g. religious practices and beliefs) or expose the afflicted person in a particular era.

Group, Residential, Community Therapies and Nationwide expectations

Sonja Levander (Sweden) described alternative settings to hospital for first episode psychotic patients consisting of 9 bedded community home-like environments. The journey of two persons through this kind of setting was described in depth to bring the approach alive for the audience. (We now have good evidence of the difference that this approach can make in terms of patient satisfaction and long term outcome as well as cost savings. An example of research demonstrating this won the research prize in this conference (1)–see Research Prize below). *Shalom Litman* (Israel) described changing the treatment practice in a local service in Israel from one using a large number of lengthy hospital admissions, followed by individual follow up that centred mainly on medication compliance. The reformed service was organised principally on dynamic group frameworks that ranged from hostel settings to community social and therapeutic groups. The local success,

once staff resistance was overcome, led to its extension to a large number of the Israeli geographical areas with marked reduction in bed usage and marked increase in successful community rehabilitation.

By way of contrast, *Reinmar du Bois* and *Michael Günther* (Germany) illustrated the therapeutic potential of a *long-term* residential therapy of resistant schizophrenia in adolescence with the intention that this time be used to promote adolescent maturation by utilising the interpersonal relationships established in the context of every day life opportunities offered in the residential setting. *Nick Kanas* (USA) gave a résumé of outcome studies of group psychotherapy highlighting variations in outcome according to approach and focus. As a result he has developed an integrated method utilising a structured focus in the more acutely disturbed, later moving to examining interpersonal relating in outpatient settings. Kanas underlines the cost-effectiveness and wide applicability of these approaches and high attendance rates.

Marvin Skolnick (USA) gave a rich account of a therapeutic community for 'chronic' schizophrenia. He was at pains to emphasise that 'chronic' is a result of complex interactions involving local society, institutions and family. The therapeutic community approach allows fresh opportunities for the "poetry" of psychotic symptoms to be understood and for its translation and development, albeit against resistances that have multiple sources.

Andrew Sims, a former president of the Royal College of Psychiatrists, gave an account of the development of Nationwide Clinical Standards for services and their potential value in improving the overall care of the whole population of persons such as those who suffer from schizophrenia, (a rather uncanny predictor maybe of eight years later when UK services are dominated by targets and 'expert' guidelines). *Pier Maria Furlan* (Italy) was the principle organiser of the 9th International ISPS symposium in Turin and his talk described many of the issues that are left in Italy in the wake of the 1978 Italian Law that transformed Italian psychiatry. He focussed especially on the lack of coordinated planning and evaluation of the intermediary facilities compounded by the lack of interest in many universities in community psychiatry.

Dame Fiona Caldicott, now that she had relinquished her Presidency of the College, was able to give a riveting account of her experience as head of a profession in relationship with politicians in moving forward a mental health agenda.

Research Prize

There were many research presentations at the conference. In the announcements for the conference, we announced an innovation for the ISPS – that there would be substantial financial prizes for the best research papers submitted. There were twenty two submissions. Nearly all were of a high quality. The unanimous choice to win the competition was a paper by *Wayne Fenton and Loren Mosher* (1), in which they randomly admitted patients to the psychiatric unit of a general hospital or an eight bedded community crisis home using an adaptation of Soteria House principles including a visiting psychiatrist. Clinical outcomes were no different but there were substantive reductions in bed days needed and savings in costs. One of the important implications of the research is that it points to a potential release of money for improved community therapies. Highly commended were papers by

- a) William Sledge, Larry Davidson and colleagues from Yale, USA on community social interventions reducing recurrent admissions,
- b) Gráinne Fadden researching the problems of implementing psychosocial interventions routinely,
- c) Dr. Moggi of Switzerland on a particular approach to dual diagnosis patients and
- d) Roberta Sciani and Orazio Siciliani of Italy on a self psychology therapy model.

The Arts, Art therapies and Psychosis

Following the opening ceremony, we were especially fortunate to have been able to engage actors from Shakespeare's Globe Company who dramatised extracts from Shakespeare and show us "that way madness lies." Our convenors were to have been *Alice Theilgaard, Mark Rylance* and *Murray Cox*. However Murray sadly died suddenly shortly before the conference.

There was also an impressive and unique exhibition entitled 'Images of Psychosis' bringing together historical and contemporary UK examples of 'psychotic' art, outsider art and art work. This was organised by Sheila Grandison, the Talbot Rice Gallery, the Aberdeen Art Gallery and the University of Edinburgh. This was the first time the Scottish Collection of Art Extraordinary had been seen outside of Scotland and included the collection of

Joyce Laing, a pioneer of art therapy and mid nineteenth century psychiatric art from Crichton Royal Hospital that predated the Prinzhorn collection.

Joy Shaverien, (UK), a Jungian analyst and art therapist gave a rich talk, discussing the use of the art object in therapy as a complex transactional vehicle allowing a sense of control over the primitive or disturbing yet being a route for the recovery of symbolic and communicative function. She expressed concern about the future of arts therapies in the changing settings where the severely mentally ill are seen. *Louis Sass* (USA) gave a very profound philosophical and phenomenological paper on Modernism, Primitivism and the madness of Antonin Artaud whereas *Abbe Steinglass* (USA) gave a visually exciting presentation making connections between the artistic process and the development of psychosis and a therapeutic intervention through looking at the *disturbing idea* of both artist and patient and the stages of transformation of that *idea* into its final visual outcome and how this and the 'idea' is affected when there is an observer of the process (e.g. therapist).

Yaron Shavit an Israeli born pianist living in London, played extracts from Schumann's last piano compositions before he made a suicide attempt by throwing himself into the Rhine. He compared these with extracts from earlier works of Schumann showing how the change of style reflected his state of mind.

The longer term outcome of the conference

It is difficult to evaluate the effect of a major conference. It needs to be considered at many levels and in many contexts. If one was evaluating the ISPS Swedish conference of 1991, would the evaluators have taken into account that one first time participant from the UK was sufficiently inspired by that conference to bring all the UK mental health organisations and the Department of Health together to put on a major international conference in the UK and its effects on the UK?

Certainly it would be impossible to evaluate the international impact of the London ISPS conference on its participants from 120 countries, though there were many favourable comments that have continued to be received over the subsequent years including indications that it motivated many persons to become actively involved in the psychological approaches to psychosis.

The approaches to psychosis in the UK

In terms of benefits to the UK, the timing of the conference was most fortuitous. The UK had recently elected a new government who had pledged to modernise the health services and that mental health was one of the priorities. Planning was underway and early intervention in psychosis became one of three pillars of the mental health modernisation announced in 1999 (alongside alternatives to hospitalisation through crisis and home treatment teams and new 'assertive outreach' services for the hard to engage and isolated patients with psychosis). Government mental health staff involved in planning modernisation of UK mental health services participated in the conference and went on to visit overseas first episode centres whose leaders had participated in Building Bridges.

It is important to remember the breadth of presentations made by UK delegates at the conference that demonstrated the extent of knowledge and expertise: users and carers, psychoanalytic approaches, arts therapies, group and therapeutic community, let alone the internationally renowned work in family and cognitive therapies with a sound efficacy base.

Perhaps the conference played a significant part in reducing the stigma that exists against the range of psychological / talking therapies and gave many participants and the presenters a sense of pride as they demonstrated their knowledge and skills to appreciative international audiences. Certainly the overall mood in the UK has been a much more optimistic one concerning psychological therapies in the decade since the conference. However the degree of resistance, the lack of systems that can lead to changes in practice, the shortage of training opportunities and career opportunities for trained staff remain formidable.

More tangible spin offs from the conference are

- the formation and considerable achievements of the ISPS UK and
- the publication that followed from the conference.

The ISPS UK

Following on from the model of the conference and its planning, the ISPS UK committee that formed after 1997 the ISPS UK network was multi-modality and multi-professional. It may be helpful for others to know the breadth of

expertise represented on our committees. Psychodynamic, cognitive, family, arts therapies, nursing, social work, group and therapeutic community, several faculties within psychiatry including child and adolescent as well as psychology and in recent years we have had user and carer participation. Its chair was determined that ISPS UK would minimise the unhealthy factionalism that impedes progress in the more widespread implementation of psychological therapies.

Clearly a number of us wear more than one hat! In 2001, ISPS UK became a recognised charity and adopted a constitution not dissimilar to that of the parent ISPS organisation with a formally elected committee who are also trustees of the organisation. In 2004, David Kennard, a psychologist who has a background in the therapeutic community field took over as chair of ISPS UK from Brian Martindale and further developments of the organisation are well under way.

It should not be under-emphasised that the crucial ingredient to transform the enthusiasm of experienced but busy clinical professional committee into a nationally relevant one was the appointment of a paid 'organiser/administrator' for one day a week. This was possible once we had organised a conference that deliberately generated sufficient funds for the organiser. We advertised nationally and were able to choose from a very good field of applicants. *Antonia Svensson* was our unanimous choice and very capably provided the means by which the growing membership was organised and established a two way relationship with the committee. Many international members will recognise Antonia's name as, following her move to Greece in 2002, she became the 'Organiser' for the International ISPS organisation and was succeeded in the UK by *Annabelle Thomas*, who came with considerable valuable experience of running conferences.

At the time of writing (2005) the organisation had some 500 members and has held three residential conferences each involving about 300 professionals and a good number of day conferences. Some of themes we have focussed on may be of interest: the residential conferences on a) *the therapeutic relationship*, b) *ways of listening, seeing and being with those with psychosis* c) *changing practice*. Two one day conferences have been held on groups and psychosis and two on the inpatient experience and in late 2005 there will be a day conference on culture and psychosis. A most useful innovation developed by Chris Burford has been a membership email discussion group which has played an important part in adding to a sense of

an ISPS UK identity by allowing members to bring 'hot' topics for others to respond to and debate as well as a ready forum for information sharing.

I think it is true to say that there has been relatively little interdisciplinary and intermodality strife in the ISPS UK because there is a place for every group at the top table and the conferences have been organised in a way in which our members can be well informed about the different approaches and a fair amount of debate and discussion about differences can be built into the meetings. The rapid growth of the implementation of early intervention in psychosis in the UK has led to the ISPS UK being a naturally attractive home for many interested persons.

ISPS UK has continued to involve the leaders of the UK mental health professional groups and to maintain links with the department of health and its regional developments in the mental health field. Subgroups have started to form on both geographical basis and on a modality basis. There is for example a regular ISPS UK psychoanalysis and psychosis meeting in London, a multi-modality meeting in the North of the UK as well as nursing and family groups that are forming. We have our own lively Newsletter that is available both on the web and in printed version to all our members.

Publications

A new ISPS book with UK authors (*Kennard, Fagin, Grandison and Hardcastle*) is to be published in 2006. It has the provisional title: *Feeling Your Way Through: Accounts, Reflections and Commentaries on the Experiences of Acute Psychiatric In-Patient Care*. There have been wide-spread concerns in the UK about the lack of therapeutic emphasis and other adverse features of wards in recent years and we have high hopes that this book's usefulness will be of constructive value to many mental health practitioners.

Following the 1997 conference, we deliberated hard as to what kind of publication would best follow on. Clearly we had available a most outstanding range of papers. With time and resources being finite, we decided in conjunction with the International ISPS Board that in view of the zeitgeist, an evidence based book would best complement the conference. *Brian Martindale, Anthony Bateman, Michael Crowe and Frank Margison*, who all had various active roles in the conference were the editors and collected together a whole range of international experts in a spectrum of psychological therapies who all produced high quality

chapters. The chapters aimed to have two functions a) to give grounding in the basis of the approach b) to outline the research evidence for effectiveness.

It was important for the UK that the book was published by Gaskell press –the publishing arm of the Royal College of Psychiatrists. The title of the resulting book is Psychosis: Psychological Approaches and their Effectiveness. Putting Psychotherapies at the Centre of Treatment (2). It has been reprinted and may well be updated in 2006.

The book certainly played an important part in ensuring that some of the momentum and enthusiasm that the Building Bridges conference generated was translated not into a museum of hopefully good memories of a conference but into a Bridge to the Future of Psychological Therapies in the UK and we hope for participants from other countries, just as the 10th and 11th conferences and their inspiration had formed an important bridge to the UK.

I am sure that all involved in the UK conference are grateful to the organisers of the earlier ISPS conferences that had inspired us.

Appendix 1

The following were the core members of the UK scientific committee, who worked closely in liaison with the ISPS Board of the time.

Administrators / Secretary

Joyce Piper

Treasurer

Jeff Roberts

Members

Anthony Bateman
Michael Crowe
Domenico di Ceglie
Suman Fernando
Kevin Gournay
Sheila Grandison
Lucy Johnstone
Malcolm Pines
Paul Robinson
Brian Martindale (Chair)

Appendix 2

The following UK organisations were actively involved in supporting the conference

The Department of Health
The Royal College of Psychiatrists (several faculties)
The British Psychological Society
The Royal College of Nursing
The United Kingdom Council for Psychotherapy (UKCP)
The British Confederation of Psychotherapists (BCP)
The Association of Child Psychotherapists (ACP)

Institute of Psychoanalysis
The Association of Psychoanalytic Psychotherapy in the NHS
Institute of Family Therapy (IFT)
The British Association of Art Therapists (BAAT)
The Association of Professional Music Therapists (APMT)
The British Association of Dramatherapists (BADth)
The Association for Dance Movement Therapy (ADMT)
Group for the Advancement of Psychodynamics in Social Work (GAPS)
Association of Therapeutic Communities (ATC)
The Institute of Group Analysis (IGA)
Arbours Association

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Brian Martindale, MD

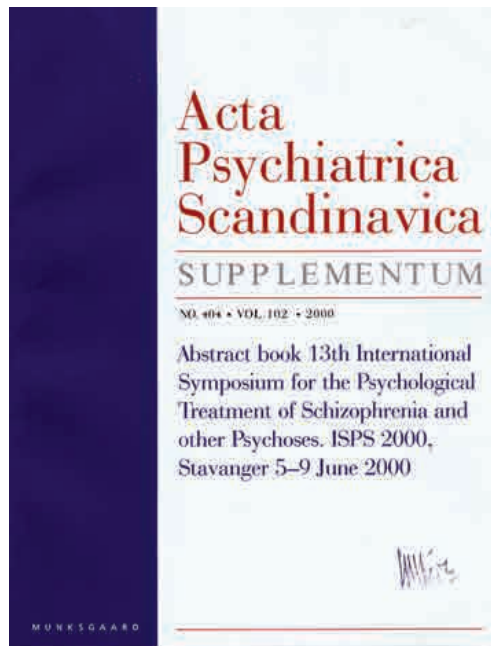
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CHAPT. 13 PHOTOGRAPHS

*2000 Stavanger 13th
International Symposium for
The Psychological Treatment
of Schizophrenia and other
Psychosis.*





*Stavanger Symposium
attendants resting outside
Venue*



*The Queen of Norway with
Stavanger Symposium
Chairman*

CHAPT. 13 PHOTOGRAPHS



Gerd Ragna Bloch Thorsen



Jan Olav in Stavanger 2000

13. The XIIIth ISPS Symposium in Stavanger, Norway, on June 2000

Schizophrenia and other psychoses: Different stages – different treatments?

Jan Olav Johannessen and Gerd Ragna Bloch Thorsen

Background

As is evident from the fact that the 5th ISPS conference was organised in Oslo, Norway, in 1975, the psychotherapeutic approaches towards psychotic disorders, such as schizophrenia, have held a strong position in Norwegian and Scandinavia for many decades. This tradition has also been strong in the part of Norway where we were trained and have spent most of our professional career. Psychodynamic understanding and psychotherapy have been, and still are, corner stones of the comprehensive treatment programs that we try to offer all patients, including those suffering from psychotic illnesses. This includes “phase-specific” and the more comprehensive “need-adapted” treatment strategies that are so important in all Scandinavian psychiatry for people with psychosis, developed via the work of Tähkä, Alanen, Cullberg and also significantly by Endre Ugelstad. In 1981 Stavanger hosted the “Scandinavian Psychotherapy Congress” where *Veikko Tähkä* presented a version of his paper on “Psychotherapy as phase-specific interaction: towards a general psychoanalytic theory of psychotherapy” (1). His work had been presented previously at the Scandinavian Psychoanalytic Congress in Helsinki in 1978, and by the early 80’s was already obtaining great influence in the Scandinavian psychiatric milieus.

This work, together with local interest for epidemiology, pointed us in the direction of working with first episode psychosis. So, locally in the

Stavanger region, we gradually developed some interest for and competence on the combination of psychotherapy with early psychosis. Further on this was combined with a recognition of the importance of empowerment, and transferring knowledge to patients and relatives, as well as the public, to reduce anti-stigma, reduce delays in treatment onset and to include patients as active participants in their own treatment. We started with public information campaigns combined with conferences for professionals from Norway. Based on previous smaller conferences, the so-called "Schizophrenia days" surfaced in 1989. This is an annual conference for professionals, the public, patients, relatives, school pupils, students and so on. It is a professional conference with a very high quality of invited speakers, with public lectures, art exhibitions, theatre, films, music and a lot of other cultural events. The purpose of these is to demonstrate that people suffering from psychotic disorders are much more than their disorder. Actually two of Stavanger's most famous artists, the poet Sigbjørn Obstfelder and the painter Lars Hertervig, both suffered from serious psychiatric disorders; a hundred years after their deaths, none of their contemporaries, so-called well functioning co-citizens, seem to be remembered. "Schizophrenia Days" is a yearly conference, not only focusing on schizophrenia, but also on different psychiatric disorders. It has grown over the years and by 2005 we had about 3000 participants of different backgrounds. This experience with organising rather large conferences was part of the reason why the Stavanger milieu was asked to take responsibility for this 13th ISPS symposium. This mixture of psychotherapy for psychosis, early intervention in psychosis and information and education work formed the local matrix in which this symposium was embedded.

The organizing and scientific committees were led by the writers, *Jan-Olav Johannessen* as the chairman and *Gerda Ragna Bloch Thorsen* as co-chairperson. Very early in the process of organising this symposium, we understood that the Stavanger milieu was too small, and our professional network too limited, to take on such an enormous task as organising the kind of symposium this really is. Therefore, we had to build on the whole Norwegian psychological/psychiatric/psychotherapeutic milieu, as well as the insight and competence of the ISPS executive board and other international professional capacities. We also formed an *international advisory board*, a *national scientific committee*, and a *local organising committee* (Appendix 1).

The theme

When we were asked to organize this meeting, it was clear to us from the very beginning that the theme should reflect the common Nordic experience of phase specificity regarding understanding and treatment of psychosis. For those of us stressing the importance of early detection and treatment of psychotic disorders, the rationale behind our engagement differs. For us, it was the personal experience of treating schizophrenic patients in different stages, meeting them for the first time when their illness had lasted, say one week versus three years, versus meeting them in the very chronic psychotic stages that one can see at times. We also knew that the psychological treatments were under great pressure to prove both their effectiveness and also their cost-effectiveness. So it was, and still is, our conviction that concentrating on the very early stages of psychoses could mean a revival also for psychological treatments, the possibility of developing better and more targeted treatment strategies, and that it would be easier for the patients to engage in a therapeutic relationship when they are offered help at an early stage in the illness development. In addition, this relationship would then be, as we very well know, the most important “tool” in resolving the intra- and interpersonal conflicts that are the basis or contribute to the psychological breakdown that a psychosis really is.

The town authorities in Stavanger as well as the county authorities in Rogaland supported the idea of applying for this important congress to come to our area. And the royal family, represented by *Her Majesty Queen Sonja*, agreed to be the royal patron of the ISPS 2000. We were also very lucky to get Professor *B. Saraceno* from the WHO to participate in the opening of our conference and give a lecture titled “WHO strategies in the field of mental health.” We had 70 workshops and symposia, 50 posters, 50 free papers, and about 15 plenary keynote presentations.

The symposium was divided into four major themes with what we saw as a built-in natural logic between them. The first day focused on “the nature of psychosis,” the second on “what kind of psychotherapy for which patient?,” the third one on “early intervention in psychosis” and the fourth on “integrated treatment: research – education – future aspects.”

In the foreword for the ISPS 2000 abstract book, *Acta Psychiatrica Scandinavica, Supplementum, No 404, Volume 102, 2000 (2)*, the organisers wrote:

“Schizophrenia and other psychosis: Different stages – different treatment. Harry Stack Sullivan pointed out already in 1927 (3) that “the psychiatrist sees too many end states and deals professionally with too few of the prepsychotic.” At the same time he also stated that “the great number of our patients have shown for years clear signs of coming trouble before the breakdown,” and “it is never easy to say just when the schizophrenic patients has crossed the line into actual psychosis.” In 1955 Lewis B. Hill (4) stated in his book “Psychotherapeutic Intervention in Schizophrenia” that “if the crisis is badly treated or is neglected, then the liability to chronic disabling illness is vastly increased. It is quite possible that the thousands of patients in the state hospitals diagnosed as chronic undifferentiated schizophrenics are, in fact, the result of inadequately treated acute schizophrenia.” These observations made by clinicians and researchers throughout the last century have led us to understand that the functional psychosis in general, and maybe schizophrenia in particular, are conditions that develop through different stages.

These disorders have different stages of illness development and the end stages may very well be the result of too late intervention in the previous stages.

The concept of early intervention has vast implications for the therapeutic approaches and especially for the way we organise our psychiatric health services. Important work has been done during the last decade in this field, with pioneers like Ian Falloon, Patrick McGorry, Max Birchwood; Heinz Häfner; Johan Cullberg to mention a few. Their work, presented at the 13th International Symposium for the Psychological Treatments of Schizophrenia and other Psychoses, gives an indication that by intervening in earlier stages, it can be possible to prevent, delay or modify the manifestation of a psychotic disorder such as schizophrenia.

Much of the research on different psychotic disorders and schizophrenia does not differentiate between these different stages of illness development; i.e. in most of the research done, all patients with a schizophrenia diagnosis are considered the same, regardless of duration of untreated illness, age, episode number, gender and so on. Future research, both psychological, psychosocial and biological, should focus more on different sub-samples within these diagnostic categories. We think, for example, that duration of untreated psychosis is highly underestimated as a prognostic factor. There are now indications from research done in Australia, Germany, Scandinavia

and other parts of the world, that prognosis could be better if one intervenes early. The patients are more compliant with the treatment, and more motivated for psychological treatments. Future research should therefore concentrate on “refining” the different sub-categories of these serious disorders according to number of episode, age, and so on.

The different contributions at the ISPS in Stavanger in June 2000 look upon functional psychoses and schizophrenias as processes and the result of internal and external factors, where the psychosis, or the mental breakdown, will be treated as such. We challenge the opinion that schizophrenia is a biological genetic disorder with an inevitable descending course. On behalf of both the patient and the people working in the field of psychiatry, we want to reinstall hope in the treatment of these serious conditions and provide future treatment in a humanistic tradition.

The nature of psychosis

Patrick McGorry of Melbourne, Australia, gave the first plenary speech with the title “The nature of psychosis: Different stages – different treatment”. He specifically addressed the concept of psychosis, and demonstrated that these are disorders that develop in stages. He stated that the optimal treatment of psychotic disorders has been viewed as independent of phase of illness until recently. He described a phase-oriented approach to treatment, with emphasis upon the earlier phases of illness and role of psychological therapies. The other plenary speech was given by *Jeremy Holmes* from Devon, UK: “Can narrative approaches help in our understanding and management of psychosis?.” He stated that narrative based medicine and evidence based medicine form a symmetrical thesis and antithesis. The task of the practitioner is to synthesise them. He stressed the need to understand the role of unconscious motivation as well as genes and neurotransmitters if you are to understand how a psychotic illness arises in the context of a particular life story. He offered an attachment based perspective suggesting that there are direct links between the physiology of attachment in infancy, the development of language, and adult narrative styles.

Other important contributions related to this theme, the nature of psychosis, were given by *Lars Thorgaard* from Denmark, who presented ideas for a therapy-directed classification of schizophrenia based on an empathic

understanding, *Phillipa A. Garety* from UK who talked about “Delusions: investigations into the psychology of delusional reasoning,” *Paul C. Bermanzohn* from US who talked about “Neglected syndromes in schizophrenia” and *Colin Ross*, US, who gave an excellent speech on “Psychoses, delusions and dissociation. The need for integration. Theoretical and therapeutical implications.”

Other symposia focused on cognitive disturbances, philosophical aspects of schizophrenia, the prodromes of psychosis and schizophrenia, and assessment of psychoses.

What kind of psychotherapy for which patient

In this part of the symposium, which was held on the second day, the plenary meeting was chaired by *Pier Maria Furlan* of Turin, the organiser of the ISPS 1988 in Turin.

Thomas McGlashan from New Haven, US, gave an overview of what he called “The potential of relationships in the work with schizophrenic patients.” He stated that these relational treatments are the oldest we have, but they are in danger of becoming remnants of the world antiquity. Therefore, he tried to demonstrate their relevance by showing, for example, the impact of psychosocial forces on the natural history of schizophrenia and to connect that to present day outcome dimensions of particular relevance to psychosocial treatments.

Max Birchwood from Birmingham, UK, gave a talk called “Threats to engagement in psychological treatment for schizophrenia.” Professor Birchwood based on the cognitive tradition, and made a point of the fact that their research group has noticed several major threats to engagement and treatment. And, in a way, these observations reach over to the more psychodynamic understanding and treatment of psychosis, where the interpersonal relationship is judged to be of utmost importance.

This day, *Gaetano Benedetti* from Basel, Switzerland, was invited to give an honorary lecture titled “The two phases of dreams in the psychotherapy of psychotic patients.” Professor Benedetti, being one of the founders of the ISPS, also received a special price from the organisers, honouring the work he has done for patients suffering from schizophrenia during at least five or

six decades. Professor Benedetti has visited Stavanger and other places in Norway on several occasions, and his work has had a major influence here.

“The David Feinsilver award” was given to a young researcher, Dr. *Zgantouri Kontantia* from Greece, who presented the award lecture “Psychotherapy process research in schizophrenia, paranoid type: the investigation of delusional formation through the evaluation in session events.”

The variety of symposia, workshops and posters addressed the topic of psychotherapy, individualised, according to single patient’s needs. *Susan Hingley* from the UK gave a brilliant overview of “The psychodynamic psychotherapy of psychosis. Theory and practice”, in the same symposium as present board member of ISPS International, *Ann Louise S. Silver*, US, delivered a speech on “The stages of treatment of psychosis.” Doctor Silver delineated the stages in the evolution of treatment of psychosis in the United States. She stated that evaluation of such stages depends on the always evolving treatment philosophy of the therapist and the organisations with which the therapist is affiliated. She contrasted the staging of treatments in the pre and post medication eras, and drew on her almost quarter of a century experience at Chestnut Lodge.

Other symposia on this day addressed multi-family groups in first episode psychosis (*William McFarlane*, Maine, US), while the well-known author *Jay Neugeboren* from New York gave a lecture on the topic “Transforming madness,” from his new book based on his experiences with his brother Robert who has suffered from mental illness for decades. We also had a separate symposium addressing the ethical issues in early intervention research on psychosis, a symposium conducted by *Franz Resch* from Heidelberg, Germany, a former board member of the ISPS, on “Psychosis in children and adolescents,” and a variety of other very important and in-depth contributions from all over the world.

Early intervention in psychosis

There were three plenary lectures on this day. The first one was given by *Tor K. Larsen*, Stavanger, Norway, who gave a lecture titled “Early intervention in Psychosis. Theory, practical models and cost/benefit.” He gave an outline of the Scandinavian multi-centre program TIPS (Early Treatment and Intervention in Psychosis) project.

Johan Cullberg of Stockholm, Sweden talked about “Experiences of psychotherapeutic intervention at different stages of psychosis.” He stressed that the acute psychosis is mostly a disorder with good prognosis in the sense that the psychotic symptoms disappear. In his experience the psychotherapeutic practice of experienced dynamic or cognitive therapists is not so different as could be believed considering the ongoing debate. He underlined that we need both aspects. *Bjørn Rishovd Rund* of Oslo, Norway, talked about “Cognitive remediation of patients with schizophrenia: Does it work?”. Neurocognitive dysfunction is the core deficit of schizophrenia. He stated that cognitive dysfunction have proven to be the best predictors of prognosis and outcome, and that the obvious area to attack is the one that is most impaired and most damaging, the person’s psychosocial functioning. This makes cognitive disorders an appropriate target for treatment and rehabilitation. Central symposia and workshops in connection to this theme were “Personality and psychosis,” “Development of psychosis in children” to name a few. *Franz Resch* gave an outstanding overview on “Psychosis in Children and adolescents: Developmental aspects,” and *John Read* of Auckland, New Zealand addressed a topic that maybe was “the talk of the conference,” “Child abuse and schizophrenia: The need for training in abuse enquiry and therapeutic response.” Milieu treatment, training and implementation, and psychologically interventions for ultra high risk populations, were other topics that were central in our presentations.

Integrated treatment: Research, education, future aspects

Wayne Fenton, formerly at the Chestnut Lodge hospital, now at the NIMH in the US, gave a plenary talk on “Depression, suicide and suicide prevention in schizophrenia.” Epidemiological data indicate that nearly 80 % with a diagnosis of schizophrenia will experience a major depressive episode at some time during their life. Suicide is the single largest cause of premature death among individuals with schizophrenia. Patients in a defined high risk group may benefit from more intensive psychosocial support to evaluate an elicited suicidal ideation during high risk periods. *Anthony Lehman*, US, summarised “integrated treatment: What does research show?”. Professor Lehman is the main author of the so-called PORT report that has suggested a minor role of psychodynamic psychotherapies in the treatment of schizophrenia. His lecture raised an intense debate and challenged the ISPS to come up with an alternative report. The ISPS board actually did this, as the Journal of the American Academy of

Psychoanalysis and Dynamic Psychiatry came out with a special issue in 2003 "The Schizophrenic Person and the Benefits of the Psychotherapies" (editors *Ann Louise S. Silver* and *Tor K. Larsen*).

Robert E. Drake, also from the US, gave a talk on "Assertive outreach treatment." Important symposia and workshops in relation to this day's main theme were on milieu treatment in psychosis, service and staff prerequisites for helping psychotic patients, integrated treatment in first episode psychosis, day treatment of psychotic patients.

Publication

Based on the most central themes of the conference, the book "Evolving Psychosis – Different Phases, Different Treatments" is issued. The process of bringing a book together with more than 20 authors from all around the world is not an easy task, so the book will surface, hopefully in the spring of 2006. Editors are *Jan Olav Johannessen*, *Brian Martindale* and *Johan Cullberg* (5).

Summary

The ISPS 2000 in Stavanger gathered about 800 participants from all over the world. The themes of plenary lectures, symposia, workshops, oral presentations and posters were wide spread and covered many, many different topics. In that aspect the ISPS 2000 was true to the goals of the ISPS organisation. It also made a good financial contribution to the organisation for the years to come, so that it has been possible to support local organisations, issue a newsletter, establish a web-site, support our book-series and allow the board to meet on some occasions to try to build the organisation even further.

The ISPS received substantial financial support from the local community and we want to express our gratitude to the town of Stavanger and Rogaland county that hosted us in a very warm and satisfactorily manner.

For the Norwegian psychiatric milieu to host the ISPS 2000 was the experience of a lifetime, an experience that we would not have wanted to miss for anything.

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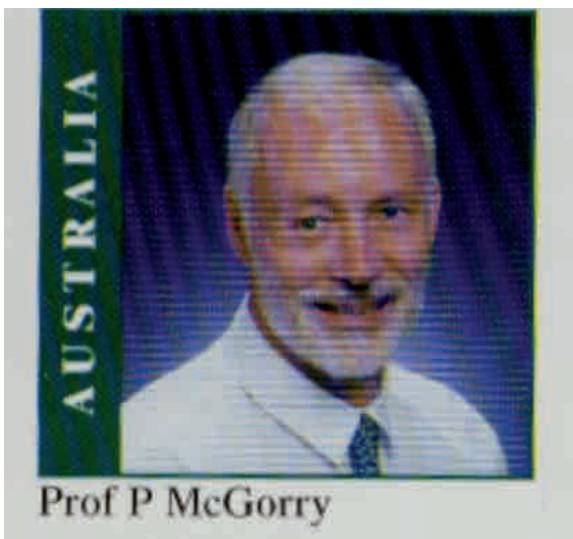
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CHAPT. 14 PHOTOGRAPHS



*ISPS Board Members in
Melbourne Symposium
2003*

*Melbourne Symposium Venue
2003*



*P. Mc.Gorry Chairman of
Melbourne Symposium*

CHAPT. 14 PHOTOGRAPHS



*J. Read, R. Bentall and
A. L. Silver in Melbourne
Symposium*



*Madrid Congress
Booth in Melbourne*

14. The XIVth ISPS Symposium in Melbourne, Australia, in September 22.-24, 2003

Reconciliation, reform and recovery: creating a future for psychological interventions in psychosis

Patrick Mc Gorry

Personal Background

From the earliest stage of my psychiatric career, I had been interested in psychotherapeutic approaches to recovery from psychotic illness. As a medical student in the 1970s, I was influenced by the iconoclastic writings of Laing and other antipsychiatrists, which not only challenged the coercive manner in which people with psychosis were responded to, but also held out the hope that innovative psychological and social interventions might have a central place in recovery. When I entered training in psychiatry and witnessed the widespread lack of a human response to patients in traditional services, I resolved in a similar way to many in the ISPS, to try to humanise the care of the seriously mentally ill. A practical and human psychological approach was going to be central to this endeavour. Many pioneers had chosen the secessionist route with some limited success (eg Soteria); however to really impact on the bulk of patients, I believed that reform would need to transform and embed itself with routine systems of care. This remains a challenge for all of us in ISPS if we wish to see psychological approaches offered to all patients.

During my training I began to learn about the interpersonal school of psychiatry, founded by Sullivan, and was deeply inspired by the writings and humane approach developed by John Strauss. I was convinced that the hope and respect for the patient engendered within this approach was a crucial

ingredient in psychosocial care and recovery for people with schizophrenia and other psychoses. Silvano Arieti's magnum opus "Interpretation of Schizophrenia" (1955) was a wonderful bridge from the psychoanalytic period to the modern era and contained the seeds of the cognitive-behavioural approach, as well as modelling synergy with the biological perspective. I also became familiar with the pragmatic Scandinavian approach to psychosis, in which biological approaches seemed to be able to coexist with psychotherapy and family and social interventions. Unlike in Anglophone cultures, where dogmatism and reductionism reigned, in Scandinavia neither biology nor psychology was neglected or devalued, and a balanced and integrated approach to the patient and family was sought. This model owed much to the pioneering work of Yrjö Alanen and his colleagues in Finland, however a flexible and tolerant approach could be found across many Scandinavian centres. Scandinavia also pioneered the idea of early intervention in psychotic disorders, through the NIPS project, conducted in the 1980s. Alanen et al. 1994. This project also integrated drug and psychotherapies in the early treatment of psychosis and provided a foundation for the early psychosis reforms of the 1990s, led by several Scandinavian centres, particularly Stavanger (Dr. Jan-Olav Johannessen), Copenhagen (Dr. Merete Nordentoft), Stockholm (Prof. John Cullberg) and Turku (Prof Raimo Salokangas).

Indeed, it was this nexus with the international early intervention network which led to my formal involvement with ISPS. Most of the leaders of the early psychosis field whom I had got to know well, for example Max Birchwood, Tom McGlashan, Jan-Olav Johannessen, and Johan Cullberg, had had a strong interest and track record in psychotherapy or psychological research. I first attended an ISPS congress in 1997 in London and was impressed by the diversity of psychosocial approaches included in the program, as well as a tacit acceptance by most participants that drug therapies played a central role in recovery for most people. Brian Martindale and his colleagues insisted and demonstrated that tolerance and celebration of diversity was a strength, and that unity among those with a commitment to psychological approaches was essential. This remains the case today and was also the message imparted to me when I was invited by Johan Cullberg to join and help form the inaugural ISPS Board. Other members of this board, Jan-Olav Johannessen, Brian Martindale, Torleif Ruud, Courtney Harding, and Franz Resch all had a similar view. This gave me great confidence that ISPS could become a credible force and platform for the reform and humanisation of psychiatric care around the world. During the 1990s, with the advent of new and better

tolerated drug therapies, the rediscovery that antipsychotic medications were equally if not more effective at low doses, and the rise of evidence-based forms of psychotherapy, notably cognitive-behaviour therapy and family interventions, the prospects seemed brighter than ever for integrated, evidence-based and humane care for people with psychotic disorders. After the great success of both the London and Stavanger conferences, my colleagues and I accepted with enthusiasm the honour and the challenge of hosting the 14th ISPS congress in Melbourne in 2003.

The Conference

The Context and Theme

The 14th ISPS Congress was the first time this meeting had been held in the Southern Hemisphere and only the third time it had been held outside Europe. Furthermore, this was the first time an international schizophrenia conference had ever been held in Australia. For these reasons, the Scientific and Programme Committees were determined to make it a memorable event, with both the science and the art of the field represented. The Scientific Committee comprised Professors *Vaughan Carr, Henry Jackson, Michael Startup, David Kavanagh, and David Castle*, Doctors *Carol Harvey, John Gleeson, Andrew Chanen, John Farhall* and myself as convenor, and we were able to assemble a program of the highest quality thanks to the calibre of the invited speakers and the wonderful submissions received from all corners of the world. Sponsorship and support was readily forthcoming from a wide variety of sources, notably Eli Lilly (Major Sponsor), the Colonial Foundation, the World Psychiatric Association, the Royal Australian and New Zealand College of Psychiatrists, the Australian Psychological Society, the Early Psychosis Prevention and Intervention Centre (EPPIC), SANE Australia, VICSERV, the Victorian Department of Human Services, Bristol-Myers-Squibb, Novartis, Mayne Pharma, Sanofi-Synthelabo, Janssen-Cilag, Organon and Lundbeck. These sponsors represented the peak organizations and pharmaceutical companies with a stake in the care of and a commitment to people with psychotic illnesses in Australia. Their support was essential to the success of the meeting and was greatly appreciated by the organising committee of ISPS, particularly that from the pharmaceutical industry, which strongly supported the congress financially, even though the main focus was clearly on non-pharmacological treatments.

The theme chosen was *“Reconciliation, Reform and Recovery: Creating a Future for Psychological Interventions in Psychosis”*. This was intended to promote integration of treatments, to challenge psychological as well as biological reductionism and indicate the need for a forward-looking and more evidence-based approach. The term reconciliation was especially meaningful to Australians due to its usage as a term for the process of healing and recovery for the indigenous people, some of whom were involved in the opening ceremony. In *my welcoming address* I sought to challenge the participants and the members of ISPS that we faced choice between renaissance and irrelevance, between moving forward in a united and professional manner, rejecting biological reductionism, yet embracing the evidence-based paradigm and the synergy between biological and psychological interventions, or gazing nostalgically into the past through the lens of psychological reductionism.

I went on to say:

“The problem with both extreme swings of the pendulum is that they involve reductionism, which is not only inappropriate given the complex biopsychosocial nature and impact of psychotic disorders, but also inadequate to bring about a good recovery and quality of life for patients and families.”....

.....“We expect our conference to be a watershed in evolving and guaranteeing a future for psychological interventions in psychosis. The complexion of psychological interventions will need to be different, more sophisticated and more effective than what has been on offer in previous eras if it is to prosper.”

This challenge of integration versus reductionism became the focus of the plenary debate of the Congress, entitled: *“Can biological and psychological interventions be integrated in the treatment of psychosis.”*

The setting for the congress was the Melbourne Convention Centre in the heart of Melbourne, next to the famous Yarra river, the only river in the world which flows upside down (it is a notorious muddy brown colour!), something by which colleagues from the northern hemisphere seemed unsurprised! The atmosphere in Melbourne was electric that week not only because the ISPS congress was being held, but also because it was Grand Final week, the week leading up to the final of the Australian Football League competition

(not soccer but Australian football!), which was played 2 days after the conference was completed, with a win for the Brisbane Lions over the Collingwood Magpies for the second year in a row.

The Conference Itself

The conference commenced on Monday 22nd September 2003 with 5 parallel workshops on Substance Use Disorders and Psychosis (*David Kavanagh, Amanda Baker and Kathryn Elkins*); Cognitive-behaviour Therapy and Psychosis (*Richard Bentall*); Psychoanalytic Approaches to Psychosis (*Brian Martindale and Ann-Louise Silver*); Family Intervention in Psychosis (*Margaret Legatt, Colin Reiss and colleagues*); and Relapse Prevention in Psychosis (*Jo Smith and John Gleeson*). These workshops covered the main psychosocial approaches and proved to be a well-attended preliminary skill-based component to the main event, creating a buzz in the lead up to the welcome reception which was held at the Melbourne Aquarium that evening. Sydney has a harbour, Melbourne an aquarium, however Melbourne is much more psychologically-minded than Sydney!

The conference proper was opened the next day with a welcome ceremony conducted by the Wurundjeri people, the original owners of the land on which the congress was being held. The conference was then opened by the Victorian Minister for Health, the *Hon. Bronwyn Pike*, who has a keen interest in mental health and a genuine commitment to the mentally ill in our own part of Australia, the State of Victoria. Welcome addresses were also delivered by myself and Dr. *Jan-Olav Johannessen*, the inspiring President of ISPS, both of which highlighted the need for integration of therapies and early intervention. They emphasised that psychosocial approaches were especially needed and likely to be most effective for young people early in the course of psychotic illness.

Superb keynote addresses from *Wayne Fenton, Fred Frese, Jim van Os* and *Richard Bentall* then followed. We were most fortunate that these high profile speakers with punishing schedules made the considerable effort to travel to Australia. Dr. *Wayne Fenton*, the former and last medical director of Chestnut Lodge, and now one of the leaders at the National Institute of Mental Health in Washington, gave a seminal address on the key theme of integration. Dr. Fenton's background made him the ideal person to argue the case for integration of perspectives and therapies, which he did most convincingly. Dr. *Fred Frese* from the National Alliance for the Mentally Ill

in the USA spoke next. For me this was the most memorable session I have ever experienced at a psychiatric conference. Dr. Frese has suffered from schizophrenia for many years and has made a substantial recovery. After overcoming the illness, he qualified in clinical psychology and went to become the Director of Psychology in a clinical service where he was once a patient. In recent years, he has become a highly effective advocate for people with schizophrenia and their families. His address was full of wisdom, humour and clear-headed guidance to the field. It was followed by an extended standing ovation, the first and only time I have seen this occur with such spontaneity and emotion at a conference. Dr. Frese's contribution was on a par with a similar performance some years back at the American Psychiatric Association congress by Dr. Kay Jamison, also a clinical and academic psychologist, and author of "An Unquiet Mind," who has suffered from bipolar disorder. Sincere thanks go to SANE Australia for facilitating Fred's participation in the meeting. ISPS should also take pride that in the fact that its most compelling plenary session was delivered by a consumer, a person with a psychotic illness. This would not have been imagined at the time that Professors Benedetti and Müller held the first ISPS meeting in 1956.

The keynote addresses continued at this standard with Prof. *Jim van Os* from Maastricht speaking on the interaction of vulnerability to psychosis with the social environment. This topic, which he and his team have contributed to greatly, illustrates the vital role that psychological and social factors play in the expression of biological vulnerability to psychosis and the onset and course of illness, and creates the space for psychosocial treatments. Professor *Richard Bentall*, who has made an enormous contribution to the development of cognitive therapies in psychosis, then gave his scholarly critique of the Neo-Kraepelinian diagnostic approach to psychotic disorder, a critique which has paved the way for a more symptom and syndrome based therapeutic approach. Highlights of the afternoon concurrent sessions were really too numerous to mention, but included Dr. *Andor Simon's* studies of recognition of early psychosis by general practitioners, Dr. *Peter Trower's* presentations on CBT in psychosis, a session focused upon substance use and psychosis, and a cutting-edge session on psychological interventions in prodromal or ultra-high risk patients, featuring work from Melbourne, Manchester and Cologne.

Day 2 of the congress faced head on one of the central issues in the field, namely the question of psychogenesis of psychosis. Trauma as a causal risk

factor for psychosis and comorbidity within psychosis was considered by three excellent keynote speakers. Dr. *John Read* commenced with an impassioned plea for childhood trauma to be recognised as a causal risk factor for psychosis, if not *the* causal risk factor. Prof. *Paul Mullen* presented an erudite, amusing and more objective review of the issue with some new data from Dunedin, which nevertheless provided cautious support for this notion. Finally, Dr. *Tony Morrison* provided a comprehensive review of the whole interface between trauma and psychosis, including the related issues of comorbidity, sequential morbidity and diagnostic confusion. The conclusion of this session seemed to be that trauma was likely to be one of the causal risk factors for psychosis as well as for comorbid complications in people with psychotic illness. Dr. Morrison subsequently edited a superb monograph on this fascinating subject.

The plenary debate then flowed seamlessly from this session and addressed the central theme of the congress, that of integration. Influenced by the views of the President, Dr. Jan-Olav Johannessen, the Scientific Committee decided to test the resolve of ISPS for integration by framing a head-to-head debate on the subject. It was therefore entitled "*Can biological and psychological interventions be integrated in the treatment of psychosis.*" Our hope was that progress towards integration would follow a full airing of the issues and the related emotions. However this debate was not one between biological reductionism and psychological reductionism, which might have pointed the way to integration. Rather it was rather "lop-sided" as a debate between those sympathetic to psychological approaches who believe in integration with biological therapies, and those who do not, and who consequently argue for a form of psychological reductionism. This was to become something of a microcosm of the whole conference. Moderated by Mr. *David Galbally*, a well-known Melbourne barrister, the debate featured Prof. *Henry Jackson*, Dr. *Wayne Fenton* and Dr. *Brian Martindale* speaking in favour of integration, and Prof. *Richard Bentall*, Dr. *Ann-Louise Silver* and Dr. *John Read* against. There was also an expert panel who listened to the arguments and offered responses. This panel comprised Prof. *Alan Fels*, a business academic and father of a young woman with schizophrenia, Prof. *David Castle*, a professor of psychiatry, Mr. *David Clarke*, the CEO of VICSERV, the peak body for NGO-based psychosocial rehabilitation in Victoria, Ms. *Barbara Hocking*, the CEO of SANE, the national mental health charity for serious mental illness, Dr. *Grace Groom*, the CEO of the Mental Health Council of Australia, Ms. *Janet Meagher*, a mental health consumer, and Dr. *Amghad Tanaghow*, the Chief Psychiatrist for Victoria. The audience also had

a substantial opportunity to contribute to the discussion. I saw the debate as a contest between passion and polemic on one side and evidence and an appeal to collaboration on the other. Years of understandable frustration with the failings of traditional psychiatry led to polarised opinions from the “no” team and a total rejection of the role of drug therapies in the treatment of schizophrenia, a position felt to be untenable by all members of the “yes” team. The panel strongly supported the perspective of integration, however the audience appeared to be quite polarised with surprisingly many people expressing at least some sympathy for the reductionist arguments of the “no” team. Speaking personally, I am not convinced that this was a helpful exercise, as the “soapbox” atmosphere seemed to reinforce to prejudices rather than promote mutual understanding and respect for opposite points of view. The positions were put with such emotion and passion that there was little room for compromise in the end. Perhaps the trajectory of ISPS since that time is the best indication of whether facing this issue head on was a wise move. It may be better to focus on what unites us rather than that which divides us within ISPS.

The remainder of the second day was taken up with a range of quality presentations across seven concurrent sessions. Key themes were family interventions, adherence-promoting strategies, psychotherapy and cognitive therapy programs and a comprehensive overview of the Danish National Schizophrenia Project, which featured supportive dynamic psychotherapy as a key strategy. Posters were displayed throughout the symposium and attracted a great deal of interest. A series of ISPS board meetings, general assemblies of both the ISPS and the IEPA (International Early Psychosis Association), and numerous meetings of national and regional ISPS groups were also held during the conference. The conference dinner was held on the Wednesday evening in the Plaza ballroom of Melbourne’s famous Regent theatre, at which the highlight was the poetic humour of Dr. Gerd-Ragna Bloch-Thorsen, which was extremely entertaining. The atmosphere at the dinner was relaxed, friendly and collegial and the entertainment (the singing waiters) arrestingly good!

The final day featured 3 more excellent keynote addresses and the presentation of ISPS awards. Dr. *Tor Ketil Larsen* presented in his typically amusing style a systematic review of psychosocial interventions in psychosis, concluding that, despite progress in recent years focusing around CBT and family interventions in particular, much more needed to be done to strengthen the evidence base for psychosocial treatments in psychosis. Dr.

Frank Margison spoke on integrating approaches to psychotherapy in psychosis, a paper which was subsequently published in the Australian and New Zealand Journal of Psychiatry (Margison 2005). This contribution was as scholarly as it was practical, and highlighted the strengths and weaknesses of integrating different psychotherapeutic approaches. The final keynote address was by Dr. *Brian Martindale*, who showed the audience, through theoretical argument and the medium of real live case material how a psychodynamic perspective could influence and enhance the clinical care of people with psychotic illness.

Following this final keynote address, a series of ISPS awards and life memberships were presented. The recipient of *The David Feinsilver Award* was *Ishita Sanyal* from Kolkata, India. Four distinguished pioneers of psychosis psychotherapy were invited to receive *The Life Honorary Membership of the ISPS: Johan Cullberg, Julian Leff, Harold F. Searles and John S. Strauss*.

The conference moved into the final concurrent session in which most of the themes explored in earlier sessions were further built upon, including dissociation and psychosis, engagement and pathways to care, multi-family group interventions, comorbidity, early intervention, group methods, CBT and psychodynamic approaches. The diversity yet solidity of these domains was impressive.

The conference concluded with a mature and inspiring closing address from the President of ISPS, Dr. *Jan-Olav Johannessen*, and a warm invitation to the Madrid Congress of ISPS in 2006 from the convenor, Dr. *Manuel González de Chávez* and his enthusiastic and friendly colleagues.

Epilogue

The 14th ISPS congress was a successful endeavour, which brought together ideas, passion and scientific data in support of psychological interventions in psychosis. It was also widely reported in the Australian print and electronic media, partly due to the controversial views expressed at the meeting. A book capturing the best work of the conference is in preparation edited by Dr. John Gleeson, Dr. Eoin Killackey and Prof. Henry Jackson from the University of Melbourne and EPPIC. Some of the material presented has already been published (eg. Margison 2005) and some has been submitted (eg. Jackson et al.). Following on from the conference both Australian and New Zealand

national groups of ISPS have been established. The polemic and polarisation of the membership and the speakers at the meeting certainly slowed this process in Australia, where psychiatrists, psychologists and other mental health professional have been quite comfortable with an integrated biopsychosocial approach to psychosis for some time. The credibility of the ISPS brand in Australia at least was affected by some of the more extreme views expressed at the conference. In my personal opinion, ISPS itself has continued to struggle since the conference with this issue, and I believe the latter has the capacity to keep psychological issues on the sidelines of clinical care unless a more pragmatic approach, modernised, yet consistent with the integrated treatment approach of Alanen and a previous generation of Scandinavian colleagues, is unambiguously embraced by the organization. This will be the challenge for Madrid and beyond.

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CHAPT. 15 PHOTOGRAPHS



First Program of XV ISPS Congress of Madrid



Dr. Chavez, Chairman of ISPS Madrid 2006

*Mirtcho Savov,
Congress Manager,
and Manuel González de Chávez
promoting Madrid Congress
at Melbourne*



*XV ISPS Congress
Madrid Venue*

CHAPT. 15 PHOTOGRAPHS



Flyer ISPS MADRID 2006



General University Hospital "Gregorio Marañón", Madrid

15. Planning of the ISPS Congress (Symposium XV) in Madrid 2006

Global Views and Integrated Therapies

Manuel González de Chávez
Chairman

“These are my people” I thought in August 1991 in Stockholm while I was attending the Xth International Symposium for Psychotherapy of Schizophrenia sessions for several days that was being held there.

It was the first time I had gone to an International Symposium of Psychotherapy of Schizophrenia. I had read almost all the books with the lectures that had taken place in them with great interest. I knew that they were forums that gathered prominent professionals with experience and dedication to psychotherapy of psychotic patients. I was able to buy the previous Symposium books, but did not know where or when the next International Symposia would be and if it was possible to participate in them.

It was Yrjö Alanen who told us that the Xth Symposium in Stockholm was going to be held. Months earlier, I had recommended to one of my collaborators from the Hospital “Gregorio Marañón” from Madrid, Dr. García-Ordás, to travel to Turku to have direct experience with the psychotherapeutic program with psychotic patients that was developed there. This was, in my opinion, one of the best examples of advanced organization of public psychiatric care dedicated to these patients.

In those years, prior to the generalization of internet, all information and organization of Symposia were done by regular mail. Alanen gave us the address of Johan Cullberg, who was the Chairman of the Organizing Committee of the Xth International Symposium and thanks to this information, we could attend some Symposia that we had only known through the reading of their books for the first time.

After having read the publications of the Symposia, attending one of them, the Stockholm Symposium, was such an unforgettable experience as having seen the photographs of scenery and then seeing it in person. Never before, in any international congress or scientific meeting had I felt so identified with the other people attending, with their work and with their professional experience, even with this simple, respectful and attentive style, so characteristic of the ISPS members, probably derived from the daily psychotherapeutic work with the sufferings and problems of difficult and complex psychotic patients. Thus, during those days, in almost each session, conference or debate, I repeated to myself "These are my people."

We received the information about the Washington Symposium very late and could not go there, as we would have liked to. But we did go to the XII Symposium of London, and the ISPS then organized as an International Society, to the XIII Symposium of Stavanger and to the XIV of Melbourne. In all of them, I have always had the satisfaction of sharing the same interests, concerns, attitudes and values with professionals from other places in the world. I can assure you that many of the people I have most admired during my professional life are members of ISPS and I also believe that our Society has been becoming, over these years, the main reference group for all the therapists dedicated to psychotic disorders.

Thus, when I was invited by the members of the Board in the spring of 2002 to organize the XV Symposium of the ISPS in Madrid in 2006, I was faced with a great challenge and great responsibility. I had to decide if I would assume all the risks, efforts and tasks of this collective project for several years.

After taking the necessary time to consider this decision and discuss it with my team and other Spanish friends and professionals, whose opinion and collaboration I greatly value, I formally presented our proposal to organize the XV Symposium or International Congress in Madrid in 2006 to the ISPS Board.

If no unforeseen event prevents it and we are able to hold it skillfully, the ISPS MADRID 2006 will give us the opportunity to personally meet again. It will be important for our international organization in the performance of its objectives and it will also allow us to establish the ISPS in Spain and perhaps in other Spanish speaking countries, achieving new members from those attending the Madrid Congress.

Madrid belongs to these great cities having the attraction and infrastructure for carrying out many international congresses every year. It is, in fact, a large, geographically well located, city with many transportation facilities. It is turistically and culturally very active with all kinds of hotels and magnificent equipment, that allow for many international congresses, conventions and fairs that are continuously held here.

In our General University Hospital “Gregorio Marañón” of Madrid we have the motivation and dedication to psychotherapy of psychoses. Furthermore, we have had experience for the last eleven years in the organization of Yearly Courses of Schizophrenia, that has an audience of more than 600 to 800 persons from all over Spain and close countries such as Portugal.

These Schizophrenia Courses , that have been attended by professors from Spain and other relevant countries in this field, have been acquiring increasing prestige and constitute a wonderful base to conduct the International Congress of the ISPS in 2006. Our objective is to organize it on the same level as the previous ones of Stockholm, London, Stravanger or Melbourne. We make an express acknowledgement of our admiration for all those who have organized the International Symposia of Psychotherapy of Schizophrenia with great merit and success.

When the ISPS Board preliminarily accepted our proposal, it decided that two of its members, Brian Martindale and Jan Olav Johannesen, would visit Madrid in January 2003 to see the possible Congress sites and agree on the characteristics and general conditions for a mutual agreement between the International ISPS and local organizing society, the Foundation for the Investigation and Treatment of Schizophrenia and other psychotic disorders, thanks to whose financing, we have been conducting the Schizophrenia courses in Madrid every year.

With our guests, we inspected the different possible sites in Madrid, that chosen for the Congress and other places of interest for the future congressmen and congresswomen. During this trip, we obtained better knowledge of the ISPS as an organization and the advice of Brian and Jan Olav on their respective experiences as organizers of the Symposia of London and Stavanger were very useful to us.

By February 2003, we were already working on the ISPS 2006 Congress. Our first task was to ask for projects and budget estimates from the best

congress organizing companies that work in Spain. We made a previous selection of the best ones and held many interviews for a careful discussion of the budgets and projects with their responsible directors. The economic budgets presented by all the companies were very similar. The cost of the organization of the ISPS Madrid 2006 would always be more than six hundred or seven hundred thousand euros, according to the number of those attending. Thus, we had to choose the organizer that offered us the most experience, credibility and quality and we personally visited their offices to know the team with which would be working during the next years better.

Finally, we chose Viajes Iberia Congresos as the organizing company. We chose it both for the ISPS Madrid 2006 and for the Annual Courses of Schizophrenia. In this way, before 2006, we would have three more scientific events, the Schizophrenia Course of each year, to synchronize the scientific committees with the professional organizers and to improve, year by year, the many tasks and innumerable aspects involved in the good organization of this type of event. At present, we can affirm that this choice was correct and we have worked very satisfactorily during all these years with the teams of competent and professional persons who make up Viajes Iberia Congresos, with their directors, André Vietor and Mirtcho Savov, and with Carmen Benavent, ISPS Project Manager and true organizational soul of our ISPS Madrid 2006.

In June 2003, we presented the budget and project to the ISPS Board and a formal contract was signed by the three of us: ISPS, as international scientific society, the Spanish Foundation for Investigation and Treatment of Schizophrenia, as local organizing society and Viajes Iberia Congresos, as Professional Congress Organizer (PCO) for the ISPS 2006 Madrid, after submitting it to legal advice, with all the responsibilities and obligations of each one of the parties.

Together with the ISPS Board, we soon decided on the congress dates, according to the possibilities of using the site chosen for it, the schedule of other events that would take place in Madrid in 2006 and that of other international congresses having possible interest for our associates. We also chose the general subjects "*Global Views & Integrated Therapies*," "*Improving Services & Helping Persons and Families with Psychotic Problems*," to stress the perspective of our Society on these disorders and the best organization of the services that we advocate, with psychotherapeutic interventions and more complete integrating programs that more effectively help both the patients as well as the families.

Knowing the importance of organizations of families and users in achieving a better quality of care received, we wanted the associations of our country (Spanish Confederation of Associations of Families and People with Mental Disease ,FEAFES) and our continent (European Federation of Associations of Families of People with Mental Illness, EUFAMI) to be integrated into the same Organizing Committee. The purpose of this was for them to indicate to us their priorities and to facilitate a fruitful exchange with the ISPS members and with those attending the Madrid Congress in 2006.

The third subject of the Madrid Congress is a fortunate coincidence: the XV Symposium or Congress of the ISPS of Madrid in 2006 coincides with the 50th Anniversary of the First International Symposia for the Psychotherapy of Schizophrenia that Christian Müller and Gaetano Benedetti organized in Lausanne, Switzerland, in the year 1956. And it is also a pleasant circumstance that after so many years, most of the organizers of all the previous international Symposia and many of the main leading figures presently continue with us and can come to Madrid to celebrate together and to receive our merited tribute in these days.

Half century of Symposia dedicated to Psychotherapy of Schizophrenia and a journey of professional meetings through cities of several continents, with increasingly greater number of persons attending and an increasingly larger range of approaches and modalities of intervention as shown by the pages of this book, whose preparation and edition to distribute it among the ISPS members and those attending this Congress, has also been a happy event.

However, one of the most rewarding aspects of the organization of the Madrid Congress has been to work with Yrjö Alanen and Ann Louise Silver, as editors, and with each one of the authors who have contributed to the preparation of this book, over the last years. I have relived with pleasure our common history and I have valued even more the effort, lucidity and dedication of those who, step by step, Symposium after Symposium, for 50 years, had made the way to opening up the road that we are now in.

The Board, the Honorary members of ISPS and the organizers of previous Symposia of Psychotherapy of Schizophrenia have done the utmost to help us. They have agreed to form the nucleus of the International Scientific Committee together with other relevant professionals of this field. Other outstanding Spanish professionals have also agreed to constitute the

Organizing Committee and to participate actively in the development of the scientific activities.

We did not want to construct the scientific program of the Congress and its main sessions, its Debates, Symposia, Workshops and Special Workshops, Lectures and other activities from Madrid, or from a supposed power. We have summoned all the members of ISPS and all those interested in this field to participate in the Congress and we have received many proposals in our web site.

All the Abstracts received were evaluated through an encoded access to our computer system that facilitates independent, multiple and simultaneous assessment and scoring of each proposal. The evaluations of different members of the Scientific Committee, according to their availability, and their areas of dedication and knowledge, have come from all the continents. They have given us their opinion and score on each Abstract, without knowledge of those of the other raters. The computer system used automatically gave us the result and mean score. We should state, with associative pride, that the Abstracts of all the main sessions have been evaluated above 7 and 8 points in a range of 0 to 10. We have thus achieved a truly democratic participation in the creation of the scientific program of this Congress.

This is the Congress of all those who wanted to participate and it has been designed and decided among all of us. At present, these are our interests and concerns, our skills, techniques, interventions and therapeutic practices, our investigations and our approach and organization developments. We are this Congress, as we were in each one of the previous Symposia. The special Supplement of Acta Psychiatrica Scandinavica, that will include all the Abstracts presented, will be the first written testimony of this moment, which will then be later on all publications of our contribution to it.

Why have we called this ISPS MADRID 2006 the XV Congress and not the XV Symposium? After having received almost 80 Abstracts for all the Main Sessions in the spring of 2005, the Organizing Committee thought that it was not adequate to continue to use the word Symposium to describe a scientific event that included 40 Symposia and several fundamental Debates, that gives us the opportunity to attend many four hour long Special Workshops and two hour long Workshops, with important participations from all over the world. This is a Congress that lasts four days and also has special Sessions and main lectures, with many posters and hundreds of oral communications.

In these 50 years of history, we have been growing in volume and active participation of those attending, in greater number of proposals with greater scope. This has made it necessary for us to organize many simultaneous sessions of Workshops and Symposia. We believed that here in Madrid it was now necessary to call that which both now, and in recent previous editions, were already truly Congresses as ISPS Congress.

How and why have we grown in the last fifty years from the First Symposium of Lausanne until this XV Congress of Madrid? In the previous chapters of this book, we have been reading and almost seeing how each one of the Symposia was carried out. All of these have been marvelously described by their own organizers or by some of their most outstanding participants. We are presently fortunate to be able to read our history, written by those who have been outstanding in it. Our historians are themselves, our history.

This has not been a period of fifty years of crossing the desert. They have been years of growth, development, maturing of all the psychotherapeutic interventions we know. They have been being discovered and unfolded. They have been communicated, taught, practiced and extended. They have shown their efficacy, helping our patients and the persons they live with and love.

Going against the current of organicistic or biologicistic, simplistic and comfortable psychiatry, the number of mental health professionals who are not satisfied with this poverty of models and approaches, with this lack of knowledge and carelessness in attention to psychoses is increasingly greater. Those attending the Symposia have grown while the psychotherapeutic practices with psychotic patients have extended. We have been meeting and knowing each other. We have listened to each other and learned one from another. We have wanted to meet again, to know our works, our advances and our therapeutic experiences.

The need to organize ourselves in the periods between Symposium and Symposium occurred very early, although it took time to materialize. The creation of ISPS was a significant step to remain in contact. It facilitated the organization, circulation, publicity and promotion of the last Symposia.

If the publication of the ISPS Newsletters has kept us periodically informed, the creation of the local networks of ISPS, with their own conferences and meetings, has allowed for knowledge, meeting and stimulus by regions, countries or territories of all the professionals of this field. Finally, we have

achieved direct communication within the ISPS and with all related professionals and persons with the development of computer science, our web pages and e-mail lists.

Based on this solid network, constructed over the years due to the motivation and dedication of many professionals, we have promoted the XV Congress of ISPS of Madrid from the presentation made in the XIV Congress of Melbourne in 2003 to the present date. The video that links Melbourne with Madrid has been distributed in all the local meetings with our flyers and preliminary programs. We have opened the web of ISPS MADRID 2006 to all types of proposals and abstracts. We have requested and received many initiatives and suggestions in the e-mail lists of ISPS.

We are very grateful to many members of the ISPS and other professionals and organizations. This congress is being conducted and constructed with the help and generosity of everyone. We have been able to transform the merited fees of well known professionals, who have not mentioned or requested them, into grants for those others of less economic income or those from developing countries.

We are going to celebrate the 50th Anniversary of the International Symposia dedicated to Psychotherapy of Schizophrenia and one century since the onset of these psychotherapies in the dawn of psychoanalysis with one and a half thousand congressmen and congresswomen in our XV Congress of the ISPS. We will pay homage to our pioneers and to our Life Honorary Members, whose number would be much greater if it was not limited by our statutes. These and many other already deceased outstanding professionals dedicated their lives and work to psychotherapy of the psychotic patients. They gave new life and hope to these patients. They are our inspirers, motivators and teachers. They are the true authors of the existence, development and organization of this XV Congress of Madrid; the creators of the reality of this dream.

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ISPS^{AND} ITS SYMPOSIA

FIFTY YEARS OF HUMANISTIC TREATMENT OF PSYCHOSES

In Honour of the History of the International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses, 1956 - 2006.



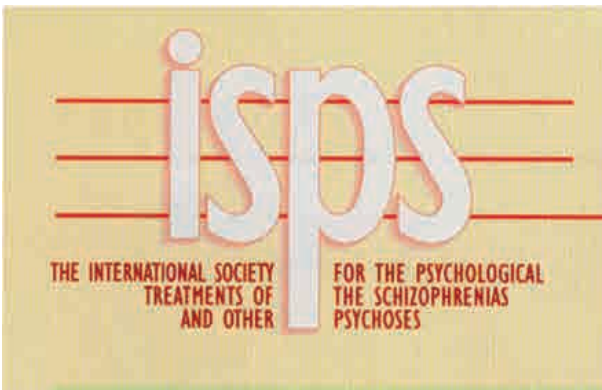
PART II:

THE ISPS TODAY

The ISPS gets organized



CHAPT. 16 to 18 PHOTOGRAPHS



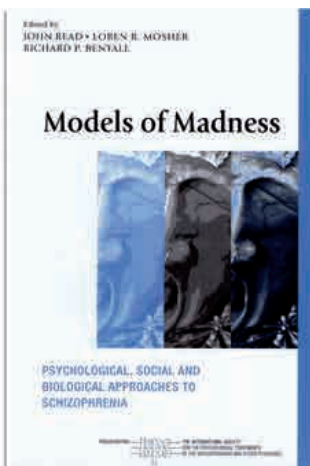
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Torleif Ruud

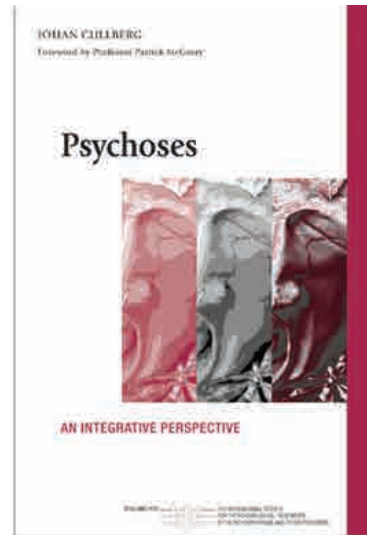


ISPS News Letter

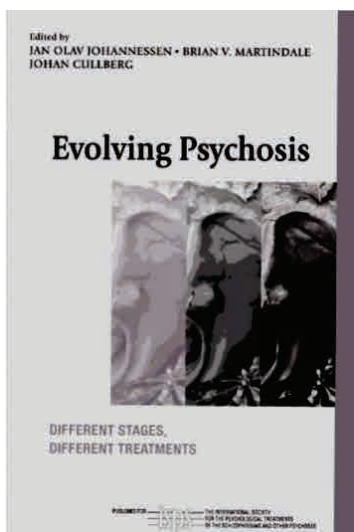


John Read, Mosher, Bentall, Models of Madness, ISPS Collection Book

CHAPT. 16 to 18 PHOTOGRAPHS



*Psychoses of Johan Cullberg,
ISPS Collection Book*



Evolving Psychosis, ISPS Collection Book

The ISPS gets organized

16. The Establishment of the International Society for the Psychological Treatments of Schizophrenia and Other Psychoses
17. Development of the ISPS newsletter, website and secretariat
18. ISPS in the Age of the Internet

16. The Establishment of the International Society for the Psychological Treatments of Schizophrenia and Other Psychoses

Brian Martindale and Jan Olav Johannessen

The reader will already be more than familiar with the fact that for the first forty years of its existence, the ISPS had the single but important function of organising *Symposia* (and now international *Congress*) every three years for clinicians to discuss their clinical work and its theoretical underpinnings. For many years these clinicians were predominantly psychoanalytically orientated. The shift to encompassing a plurality of approaches was gradual and was already visible in the 1980s, especially in connection with the Turin conference of 1988, which was held at a time when family approaches to psychosis and other disorders had become very topical and an evidence base for their effectiveness was beginning to emerge. The introduction of the so-called 'need-adapted comprehensive treatment strategies', especially in the Nordic countries, also made a significant contribution to this broader and more integrated orientation.

During these years the ISPS acronym stood for the International Symposium for the Psychotherapy of Schizophrenia.

The gestational period of the *Society*

The broadening of the functions of the ISPS had a gestational period of about 6 years. The most important figure in promoting the idea that the ISPS

should develop a broader range of functions and activities was *Endre Ugelstad* from Norway. Endre Ugelstad was well known in his country and in the ISPS for his encouragement of long term supportive psychotherapeutic approaches for those with psychosis and for his skilled supervision of staff in carrying out this dedicated work. He had a psychoanalytic training, but the kind of work he encouraged could be carried out by all clinicians who had the capacities to form relationships with the psychotically vulnerable and he believed fervently that maintaining good long term relationships should be a primary objective for clinicians and this in itself would lead to considerable improvements in their quality of life of the patients.

Ugelstad was active in promoting the changing function of ISPS during the Board meetings in Washington in 1994 and we are sure he was delighted that Dr *David Feinsilver*, the President of the 1994 ISPS symposium, was keen to make this a reality. Up until 1994, the President of the next conference was the President or Chairperson of the ISPS Board which was composed of the organisers of past conferences and of the next one. When London was chosen in 1994 for the 1997 conference, *Brian Martindale* declined the chairmanship because of the need to separate the development of the organisation from that of organising the conference and *Johan Cullberg* was elected to continue as the President of ISPS during this critical phase of its development and transformation.

There is a lot in a name!

We recall much earnest discussion at a Board meeting in Johan Cullberg's Stockholm flat as to whether to and how to adapt the name. In the end a number of points of view were retained:

- a) the need to retain the title letters of ISPS if possible in order to offer continuity of association and identity with its earlier life
- b) the need to find a form of words that would contain the word schizophrenia as well as encompassing other psychoses. This was because of a concern that if we dropped the word schizophrenia, our message that verbal therapies are relevant to those given that diagnostic categorisation might get lost. On the other hand we wanted to legitimise our involvement with a wide range of other psychoses.

c) we wanted to indicate that the new society was open to a broad range of psychological approaches and therefore we chose the words psychological treatments. This is because the term psychotherapy in some countries is synonymous with psychoanalytic psychotherapy. We also wanted to keep our boundary to the psychological as there are many organisations focussing on the social aspects of psychosis.

So after much juggling, we retained our name as ISPS but its former full title of International Symposium for the Psychotherapy of Schizophrenia became transformed to the International Society for the Psychological Treatments of Schizophrenia and other Psychoses!

A constitution is born

In the two years before the London conference, much work was done in preparing a constitution. Much of this was drafted by Brian Martindale who had previous experience of developing a European wide organisation for psychotherapists (the EFPP).

Our main objectives were to provide a relatively simple framework within which individuals and groups of individuals at different levels, local, national and international could begin to plan activities relevant to the general field of psychological therapies of psychosis that made sense to them and to ensure that there was an international network that would support and promote groups of persons. Constitutions are rather boring documents but they should be a base from which exciting things can be done and so has been the case with the ISPS.

The ISPS objectives

Here are the objectives as laid out in the new constitution:

to promote the appropriate use of psychotherapy and psychological treatments for persons with schizoprenias and other psychoses.

to promote the integration of psychological treatments in treatment plans and comprehensive treatment of all persons with schizoprenias and other psychoses.

- to promote the appropriate use of psychological understanding and psychotherapeutic approaches in all phases of the disorders including both early in the onset and in longer lasting disorders.
- to promote research into individual, group and family psychological therapies, preventative measures and other psychosocial programmes for those with psychotic disorders.
- to support treatments that include individual, family, group, and network approaches and treatment methods that are derived from psychoanalysis, cognitive-behavioral, systemic and psycho-educational approaches.
- to advance education, training and knowledge of mental health professionals in the psychological therapies and psychosocial interventions in the treatment and prevention of psychotic mental health disorders for the public benefit regardless of race, religion, gender or socio-economic status

The constitution was agreed and therefore the new society inaugurated during the ISPS conference held in London in 1997. Since the momentum had gathered full pace in 1994, we had experienced the most untimely death of Endre Ugelstad in 1996 and sadly David Feinsilver's illness also proved to be fatal.

Johan Cullberg was our first chairperson following inauguration and creatively steered a lively active international committee and the organisation through to 2000 during which time the very developments that the formation of the society was intended to foster began to appear. *Jan Olav Johannessen* took over as chair from the time of the 2000 meeting in Stavanger and the organisation has undergone considerable further development during these last years.

An organisational base

The ISPS was especially fortunate to have in its midst a protégé of Endre Ugelstad – *Torleif Ruud* – who did a great deal to lay the organisational foundations of the new organisation. He arranged for ISPS to be registered in Norway and hence free of tax expectations. He arranged for an

administrator to take care of the daily matters and finally he became the editor of the impressive ISPS Newsletter and webmaster of the ISPS website (www.isps.org). These communication means have played a crucial part in helping ISPS members gain a sense of being part of an international community and to have available information about developments that serves as a source of encouragement and ideas to those in other countries.

ISPS networks – 57 varieties

The new international society formed with the intention that it would encourage professionals and others to be much more active in between major conferences in ways that would promote psychological therapies. Perhaps this has been the most important consequence of the formation of the new society. We now have a considerable number of networks around the world, and are represented on all five continents. The USA and the UK have several hundred members each. Lively groups have formed in the individual Scandinavian countries. New Zealand and Singapore now have active networks. We are not strict about geographical boundaries and some groups have formed across national lines, for example the Flemish speaking ISPS group and the Central European group under *Ivan Urlic's* initiative. A group has formed in Israel and before long we will have networks in Germany and Spain. In some countries the networks have organised themselves into more local groups. For example the USA has groups that meet in a number of the major cities and a Northern group has formed in the UK. Some whole networks are composed of persons interested in a particular modality; others are expressly multimodality from the beginning out of which subsections form.

Overall there is an exciting sense of an organic process of development of networks on a global basis that should do much in the long term to ensure the viability and vitality of psychological approaches and that they occupy more of the centre stage in treatment services.

These networks are evolving a whole range of different functions. Some networks have already held a considerable number of local and national ISPS conferences and have their own internal newsletters. Some have set up local groups to discuss and assist clinical work (there are now two psychodynamic groups in different regions of the UK). The UK and the USA have their own email discussion groups and more recently an international

discussion group is taking off. Carer and user participation is becoming a more prominent feature.

To further promote the organisation, the board seeks to be present with information material, books, brochures etc at the most important international congresses. This, together with publishing the Newsletter, puts some economic strain on our organisation, and the financial situation is a topic that attracts a lot of energy. We have no obvious sponsors except for our individual members, but we now offer the possibility of institutions and organisations to become members themselves. In time we hope to earn some money from book sales.

Publications

In the last decade, there has been an increasing emphasis on evidence based approaches to treatments. This is problematic for psychological therapies especially in such a complex set of disorders as the psychoses, but the Board support the publication of an evidence based book on the psychoses following on from the 1997 inaugural meeting.

Psychosis: Psychological Approaches and their Effectiveness: (Putting Psychological Treatments at the Centre of Treatment) was the result and from a UK point of view it was important that the book was published by the Royal College of Psychiatrists in conjunction with the ISPS. The editorial team of this book was formed by *Brian V. Martindale, Anthony Bateman, Michael Crowe and Frank Margison.*

A most successful venture was an international group that set itself up to challenge the PORT report (an influential USA set of recommendations about treatments in schizophrenia). This led to alterations in some of the revised recommendations and to a most useful volume of *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* Vol 31, No. 1, Spring 2003. Special Issue: *The Schizophrenic Person and the Benefits of the Psychotherapies—Seeking a PORT in the Storm.* Guest Editors: *Ann-Louise S. Silver and Tor K. Larsen.*

The Board then agreed the need for a series of books and to have an international publisher. By the time of this publication, the ISPS series published by Routledge should have six volumes available. The series editor is Brian Martindale.

- Models of Madness (John Read, Loren S. Mosher and Richard .Bentall)
 Evolving Psychosis: different stages different treatments
 (Johannessen, Martindale and Cullberg)
- Psychosis (Cullberg)
- Psychosis: Working With Families and Groups of Families
 (Trond Grønnestad, Anne Lise Øxnevad and Gerd-
 Ragna Bloch Thorsen)
- Dead Landscapes: Psychopathology, Psychodynamics and Psychotherapy
 of Schizophrenia (Gaetano Benedetti)
- In-patient Therapies in Psychosis
 (Kennard, Fagin, Hardcastle and Grandison)

At this point in time, the ISPS Board is exploring the feasibility of an international journal for the Psychological Therapies of Psychosis. This is a major undertaking and will need careful preparation if it is to be viable.

The future

Others will make their own comments later in this volume about the future of the ISPS. We see the development of local networks as being the engine of change of practice. Research has shown the difficulties of moving professionals on from a training in psychological therapies to actual use of skills in clinical practice. A considerable component of this problem in our complex and difficult work is the lack of skilled support and place for regular discussion and supervision of clinical work. Hence an important component of networks will be to encourage the development of more local support groups. An important additional aspect of local groups will be the development of organisational and political skills to effect change at macro service level planning. Publications –both professional books, possibly a journal and Newsletters will all be important methods of sharing information and innovations as will increasingly sophisticated use of electronic communication including video communication. Our conferences both local and international will continue to have many functions in supporting and encouraging the networks.

Together with other organisations such as the WAPR (World Association of Psychosocial Rehabilitation), the IEPA (International Early Psychosis

Association, and the World Health Organisation we would like to engage in building and transferring competence in the psychological treatments by offering practical support for specific sites, and by connecting sites that would want to learn from each other.

We have also become an affiliated organisation of the World Psychiatric Association for several reasons not the least of which is to demonstrate the place and the room for psychological treatments of psychosis within such large organisations both now and into the future.

Taking a global perspective, the future of the psychological therapies in psychosis is looking relatively brighter in many countries compared with a decade or two ago. This is not to say that in most countries mental health systems are still dominated by the search for unrealistic short term solutions acting synergistically with rather restricted explanatory models in these complex disorders. Users and carers voices are playing an important part in changing the approaches of many professionals and in addition much will depend on how well organisations such as the ISPS support professionals in their own learning and then becoming effective at researching and 'selling' their products.

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17. Development of the ISPS newsletter, website and secretariat

Torleif Ruud

This chapter describes briefly the development of the ISPS newsletter and website, as well as the secretarial and financial services.

The ISPS newsletter

The ISPS newsletter was started in 1994 by Endre Ugelstad as the first editor when ISPS after the symposium in Washington was developing a more formal network and preparing to become a society. Before Endre died in 1996, Torleif Ruud was asked to take over as editor, and he has continued as editor up to the ISPS congress in 2006.

The newsletter has usually been published two times a year, but only once some years.

The first issues of the newsletter were printed in Norway and in black and white. For a couple of years in the late 90s the newsletter was printed and distributed by a congress bureau that was engaged by ISPS to give secretarial services between the congresses. The logo of ISPS was selected by the ISPS board in collaboration with the congress bureau during this phase.

Since ISPS in 1998 made a contract with SEPREP in Norway to be a secretariat, the newsletter has again been published and distributed from Norway. After a period where the editor also did the layout, Ellen Jepson in Stavanger has been engaged as graphical designer to make the layout. Her work and the change to full color printing of the 16 pages newsletter greatly improved the visual quality. Since Antonia Svensson has been engaged part time as organizer for the ISPS, she has done most of the work of gathering and proofreading material.

The aim of the newsletter has been to communicate ideas and experiences between members and a growing number of local groups in the expanding international network. As the local groups have developed, there have been more reports from their meetings and other activities. The newsletter has also contained book reviews, brief biographical sketches of honorary members, brief reports on research or clinical work, and information on upcoming meetings and other events. The newsletter has been sent to all members, and it has also increasingly been spread through local groups and in congresses as information on ISPS to recruit new members. During the last years 3-5000 copies were printed and distributed of each issue. The newsletter has also been available in an electronic version on the ISPS website.

The ISPS website

Preparation of the ISPS website www.isps.org was started in collaboration with the congress bureau that arranged the ISPS congress in London in 1997, but was then transferred Norway when the ISPS board decided to have its secretariat in Oslo, as described below.

The website company Netpower was chosen for several reasons. ISPS had good experiences with the work they had done for the ISPS congress in Stavanger 2000, they were less expensive than other companies we checked, and they had developed website modules we could manage ourselves to publish material on the website without having to pay extra for such daily work.

The collaboration with Netpower on the choice of modules and the design of the website was done by Torleif Ruud, and Ellen Jepson was involved in the graphic design to keep some visual similarities between the newsletter and the website. Torleif Ruud became editor of the website in order to coordinate the publishing in the newsletter and on the website. Most of the work with posting material on the website has been done by Antonia Svensson within her part time job as ISPS organizer. The website has been in operation since 2003.

The website contains information on the ISPS, information on local groups, information on upcoming events and reports from recent events, book

reviews, lists of recommended articles and books, and links to other websites. Visitors to the website may sign up to receive email messages on news as they are published. Electronic versions of all the newsletters since 2000 are also available on the website. There is also a membership form that can be used to sign up as members of ISPS, as well as information on how to form local groups.

The website has several possibilities that we are not using fully, and we realize that we are just in the beginning of exploring and developing its potentials for ISPS.

One of the great potentials is that all local groups may have their own website for free within the ISPS website. The access to these is through the expandable menu system, but we have also the possibility to let each local group have their own web address leading directly to their own website, like www.isps.org/uk, www.isps.org.us and www.isps.org/nl. The US chapter of the ISPS has also developed their own website www.isps-us.org with links to the ISPS website.

With the developments of local groups, there has been a gradual increase in material published on the website. But this has not been enough to have news as often as we would wish. Increasing use of the website by communications and publications from members and local groups is a goal, as this also is an important factor to increase the number of visits to the website. Another important factor for a website to be found by people searching the internet is to have mutual links to other websites, and this also needs to be developed further.

A possibility to run discussion groups on the ISPS website has not been used much by the members. But an Email discussion group organized by Chris Burford in the UK has been used much by many of those who have access to it. This has been an important forum for discussion between active members of ISPS across the world.

SEPREP as a secretariat for ISPS

In the phase of preparing the ISPS as a society, the needs for a secretariat was planned to be taken care of by a congress bureau. When the first board of ISPS decided to leave this model, the board chose to make an agreement

with SEPREP in Oslo to have secretarial functions for a low fee. SEPREP (Centre for Psychotherapy and Psychosocial Rehabilitation for Psychoses) is a Norwegian competence centre and network of clinicians, researchers, users and carers sharing the same objectives as ISPS. SEPREP is organising nationwide multidisciplinary training programs in treatment of persons with psychoses, and spreading information on psychoses through a bulletin and other media. Endre Ugelstad, who was active in developing ISPS as a network into a society, was one of the founders of SEPREP in 1990.

The choice of using SEPREP as a secretariat was on several reasons. SEPREP could offer a secretary that was available all work days, and still to be paid only for the hours working with specific tasks for ISPS. This secretary would also keep the books for the ISPS accounts. Collaboration with this secretariat was also easy, as the ISPS editor and treasurer Torleif Ruud at that time was chairman for SEPREP. It would also be useful to have the secretariat in Norway as the next ISPS congress was going to be in Norway in 2000.

Wenche Løyning in SEPREP has since 1999 worked part time for ISPS as secretary and book keeper. Letters and newsletters to members and local groups have been distributed by Wenche. The secretary has been available daily for ISPS, but ISPS has only paid for the amount of hours she has used on specific task for ISPS, not for the availability. ISPS is grateful to SEPREP for these services and support.

From 2003 ISPS has engaged Antonia Svensson as a part time organizer. With her professional training in psychology, she has been able to do work that a secretary could not do, and that ISPS board members did not have time to do in their unpaid spare time work for ISPS. Antonia had experience from similar work for the ISPS local group in the UK, and she was engaged on the basis that ISPS UK had been very pleased with her work. As an extended member of the secretariat, she has taken care of several important tasks related to board meetings, contact with local groups, collecting of material for the newsletter and publishing material on the website. She has worked in close cooperation with the chairman, the board, contact persons in local groups, the secretary in Oslo, and the editor of the newsletter and website. Antonia was first based in London and then moved to Athens. She has done most of her work using Email, but she has also attended ISPS meetings.

ISPS accounts and treasurer

Brian Martindale was treasurer the first years after the inauguration of the ISPS as a society at the congress in London in 1997. When the secretariat of ISPS was established in Oslo in 1999 Torleif Ruud became treasurer. The accounts were started with the transfer of a surplus from the London congress in 1999 and the transfer of a small amount that Endre Ugelstad had collected from members of the ISPS network between 1994 and 1996. The account books have been kept by Wenche Løyning, secretary of the SEPREP secretariat in Oslo.

The work and development of ISPS as an international society was made possible by the large surplus generated from the ISPS congress in Stavanger 2000. The board realized that it would take several years to establish an organization that could get adequate funding from membership fees, and chose a strategy that the international congresses every third year would give a surplus to run the society in the years between the congresses. The plan was to use the money of the society on activities that were considered to create and stimulate local groups and increase the number of members. International congresses, local or national meetings, having a part time ISPS organizer, contributing to start of local groups, the newsletter, the website, publishing of books and board meetings (mostly at international congresses to save travel costs) were considered to be such key activities and investments to build the ISPS as an international society. In this way the board to the decision and priority was to use the available money over the next years.

The expenses increased as the international and local activities increased. The congress in Melbourne in 2003 only generated a limited surplus, but the activities could be continued using the part of the surplus that were still left from the congress in 2000. Increased expenses to edit and print a quality newsletter and increased distribution costs due to large number of copies being sent to local groups were discussed by the board several times, but the board decided to keep on with the newsletter as it was one of the few reasons to become a member.

The state of the accounts and overviews of income and expenses were presented at the ISPS business meetings in Stavanger in 2000 and in Melbourne in 2003. The finances has been reported and briefly discussed in most board telephone meetings. As we approach the time of the ISPS

congress in Madrid in June 2006, there will be little or no money left in the ISPS accounts, and society and the new board need face the challenge on how to proceed.

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18. ISPS in the Age of the Internet

Chris Burford

Internet is one of the remarkable emergent phenomena of the late 20th century, transforming human relations for good and bad on a global basis.

The interlinked global financial system is mirrored by a new emergent global civil society. How healthcare is managed is one of the key areas of debate, of investment of money and human energy, and of a struggle to make that investment responsive to social control. Yet with drug companies manufacturing new anti-psychotics competing globally for a market now worth several billions dollars a year, if anything it feels more difficult for members of ISPS to get psychotherapeutic approaches on the agenda than 50 years ago. And the competitive ratio for these large drug companies is about one sales representative for every 5 doctors. We instead need to network to get the alternative priorities across.

Fortunately mental illness, including one of the greatest scourges, psychosis, is a key area of concern to people across the world. Through families or friends most people are aware that the horror of insanity, is part of the risk of being human. We have to build our links internationally understanding the human and social dynamics that underlie successful use of the technological possibilities of the internet.

The technicalities of the internet are a shifting terrain, which shapes new possibilities of communication and stifles old ones. Viruses spread across it faster than migratory birds, or mass air travel can spread more familiar diseases. These in turn are answered by anti-viral defence systems, which at least some of the better off population of the world, such as perhaps ourselves, can afford.

So the triennial ISPS Symposia, started 50 years ago by our heroic founders based in counties somewhat adjacent to the main stream of European and western academic culture, and which have survived the onslaught of biological reductionism over the decades, now have new possibilities of communication.

One suspects that participants at the first symposium did not all travel by air. What has survived as an important coalition of islands of resistance, perhaps each in their own circumstances for somewhat accidental adventitious reasons, can now communicate 24/7. But this is like the old curse of the devil granting your most heartfelt wish, a story that probably occurs in many different cultures and languages. The joy of almost instant, infinite global communication can bring experiences themselves analogous to psychotic crisis in an individual, if not an actual epileptic fit. One of the paradoxes is that the most prominent international figures are probably even more vulnerable than most, because of having achieved such a high level of connectivity already, within their workplace, their profession, their country, their academic circles and their participation in international conferences of a more conventional nature. Just one more connection might destabilise the whole house of cards, or leave their “mail box full” and inaccessible to everyone.

What are the technical constraints of the internet for us?

The creation of the internet gives one possibility for an international organisation: to create its own webpage. Search engines can locate this for you. As I write this article Google has in 0.12 seconds just given me over 23 million links to web-pages linked with the letters ISPS. Fortunately only the first 10 are listed and they all seem to have something to do with things called ISP - internet service providers.

But by adding “mental” after “ISPS” to the search term, the choice is reduced to slightly under a quarter of a million.

Even better the first three, miraculously are

“[PDF] UNITED STATES CHAPTER”

and

“ISPS-US: About Us”

followed by

“ISPS”

“Conference Report: “Society and Mental Health” 4th Stavropol Conference. ISPS wants to promote better knowledge of the psychological approaches ... www.isps.org/ 16 Dec 2005 - Cached ”

It would of course have been slightly more diplomatic for international relations if the international website had been listed before the US one, but since Google’s search rules are secret, to avoid attacks by viruses and hackers, we should not grumble.

We only have to click on one of the links, speedily to get to the internet hub of ISPS, its website www.isps.org.

The internet is about no one point of view being dominant but allowing a choice of routes to your goal. It is thoroughly post-modernist. As the international ISPS site and the US ISPS site support each other with cross links, this is a good start. The seeker to have learnt which search terms to enter into a search engine like Google.

A website such as www.isps.org or www.isps-us.org can be updated with information as regularly as time and money permit, but is competing in an environment in which there are now 8 million websites.

One measure to increase visits, is that visitors to the ISPS international website can now request a prompt whenever it is updated and a further visit is indicated.

One activity that can promote more interaction is a bulletin board. This was an early form of communication in the internet, where discussants go to a single place and add comments under particular themes or “threads”. There is this facility on the international website of ISPS www.isps.org, but it has not been much used because it has not generated much traffic, and it has not generated much traffic because, so far, it has not been much used. The secret of these internet networks is traffic: its movement, control and guidance. Hopefully contacts with or “hits” on the ISPS website have been promoted by a further initiative, ISPS-INT, an Email information/discussion list, which is the main subject of this article. (In the US this is called a listserve, after the programme that first successfully organised this activity).

An Email list echoes the corresponding societies of the 18th century and the radicalism of the later Enlightenment, and the French Revolution. In the

ferment of ideas the radical intellectuals of the new middle classes had the interest and resources to arrange to circulate any letter from one of their members to all their members, through the new postal services. These were expensive enough to exclude the majority of the population but cheap enough to make them a source of ideas subversive to the old absolutist monarchies.

With the power of computers it is now a simple measure to arrange that a letter sent to a list of 100 can be distributed to all 100, provided the computer owner is paying the cost of the machine, the software, the connection to the internet, and now, indispensable, regularly updated protection against viruses. A potentially ever growing society of like-minded discussants can form across the world. The warmth of the human connections made during the intensity of a symposium can be carried on afterwards, during the three years of relatively isolated endurance, before the next symposium. But this blessing is a curse if it is not placed in a humanly manageable context.

Fortunately ISPS has now experience of two Email information discussion lists that have been going on for more than six years: in the US and in the UK. The US has been moderated by Joel Kanter, whose support and cross fertilisation I warmly acknowledge, now with the added administrative skills of Karen Stern, executive director of ISPS-USA. The character of the two lists is somewhat different. Although the UK list is only a few weeks older, during this time it has seen under 3,000 letters, the US list over 12,500. All are still accessible in the archives.

A list is a living relationship and is shaped as much by the members, their experiences and their attitudes, as those of the list moderator. It is not possible to predict exactly how a list will develop. It is like a plant or an infant, which has to survive and grow with tender loving care, and occasional shaping, guidance, or even more rarely, pruning.

A list is also a creative dynamic between those who want to discuss and those who want to read. All discussants can be assumed to be readers at least from time to time. Most readers are not discussants. The ratio needs to be about 10:1 or 20:1. A more equal ratio leads to a list that is a chat room of intense interest to the participants but of doubtful interest to many others. In the feverish superfluity of the knowledge economy, there is an abundance of choice of commodified bits of information, and links. In an overabundant economy competition, so the economists say, is through quality. What links give the best signal to noise ratio -

as judged by the punter, the internationally known researcher, the psychoanalyst who has worked for 30 years with psychotic patients?

In a relatively stable orderly list with a large membership, most people stay on it to scan what is going on, including what might be new or controversial. It is therefore like scanning the letters page of hopefully a favourite journal: you look out for authors or themes of particular interest to you.

For a group it allows the individual members to scan the movement of the herd. But if there are very few contributions at all it is hard for the members to get the necessary information. The amount of transactional energy falls too low: there is little reason to unsubscribe, but little reason to join.

An early list may be like a small bright hot star, with lots of energy. There may be passionate exchanges, sometimes called flame wars, in which the rules of email circulation can rapidly produce a multiplying chain reaction. Even if only half a dozen people are involved, the letter boxes of everybody could easily be filled up with 20 communications or more a day, about an argument that most people would prefer to avoid. An old list might be like an old blue giant star, large but with little activity going on, losing energy, and fading away, until by chance drawn into a larger conglomeration of communications traffic and energy, that best meet the consumers' sense of quality: a good signal to noise ratio.

These delicate dynamics suggested that the launch of an international E-mail list for ISPS was therefore something that would not necessarily occur spontaneously. It might have occurred by the US becoming more open to international participation, particularly because of its rich range of psychodynamic viewpoints. A disadvantage might have been that it has played an active role in helping members of the US chapter bond together as a society, with already a high number of daily E-mails, many of them to do with local conditions of work, mostly outside mainstream mental health services. By contrast the UK chapter of ISPS had the advantage of a membership based largely in the state sector, with a cohort of psychologists who have developed therapeutic initiatives along CBT lines, and responding to government directives for more "psychosocial" and user friendly service interventions. But the UK list is relatively weak on psychodynamic contributions, and individual therapeutic interventions.

Besides at a time of controversial hegemonic wars against terrorism involving both the US and UK, it was perhaps more diplomatic not to offer a takeover, especially because the lingua franca probably had to be English.

With enough vision and enough determination, it therefore seemed desirable to try to front-load a new E-mail list, launching it on the back of the last international symposium in Melbourne 2003 by giving complimentary membership of the list to those who attended the symposium.

The first need was to get the general blessing of the international board of ISPS at a time when the board members were very busy dealing with enough E-mails already, and were investing energies and resources in developing the international website, www.isps.org. Complimentary membership of the UK list gave some opportunity for board members to decide what might be involved and whether this might be useful even though they could not read every E-mail themselves.

Careful thought needed to go into making sure the initiative was seen to be complementary and not in competition with the website initiative. One of the methods was to ensure that links to the international website were automatically added onto every E-mail message. Another was to flag up on the E-mail lists news of additions to the E-mail site. The discussion board on the website had to be tested to see how much this facility met the developmental needs of ISPS under present conditions. Hopefully these initiatives are felt on balance to be genuinely complementary.

The goal was therefore personally to invite as many participants at Melbourne ISPS 2003 to subscribe to an international E-mail information/discussion list, from as many countries as possible. Personal contact was important not only to establish some degree of trust, but because the Australian data protection act, had rather strict conventions. There was also the question of equity in an unequal situation. To avoid the new list being dominated by the British or the Americans, who were well used to E-mail, it was necessary to concentrate first on identifying participants from other countries. There were also large contingents from Scandinavia, Australia and New Zealand. It was at that time unclear whether they wanted to use Melbourne as an opportunity to launch their own Email information/discussion lists, and perhaps in languages other than English. With the support and understanding of representatives from these countries, the

compromise was to invite membership from presenters at Melbourne in their cases, and in all other cases from all ordinary members. By October 2003 and with crucial help also of Antonia Svensson, ISPS International Organiser, members were enrolled under appropriate email addresses from over 20 countries.

The feedback was interesting. One internationally valuable researcher apologised in a friendly fashion explaining that he already received 150 E-mails a day. Another member of the ISPS board felt unable to join, no doubt for the same reason. But all other board members did.

The launch in December 2003 was therefore very tentative. In order not to startle the horses, as we say in idiomatic English, I tried to set the scene very gently as if this were the closing session of Melbourne 2003, that as the lights gradually became stronger, we could see we were all sitting there still. I promptly received an unsubscription from a member with a good research record, who wished to be saved from the poetry. An important ISPS researcher also unsubscribed understandably perhaps because the list cannot really function as a highly focussed research list. But on the whole there have been remarkably few unsubscriptions. All posts remain "moderated" which is a bit unusual but allows members not to be irritated by the occasional aberrant E-mail going to 150 people. I still often however receive messages saying

Jag kommer att vara borta från kontoret fr.o.m. 2005-12-16 och kommer inte tillbaka förrän 2005-12-21.

Jag kommer att svara på meddelandet när jag kommer tillbaka.

I am away from the office until 21/12.

but continue to have difficulty contacting the individual to ask him or her to amend his Microsoft "out of office" settings. Mastering the technology is a challenge for all of us. Naturally I do not approve of these messages for circulation to the rest of the subscribers.

Moderation also allows me to tweak contributions from across the planet, from brave people for whom English is not their mother tongue, particularly for things like prepositions, which are very idiomatic. I think there is perhaps a problem that whereas in an international conference face to face, armed

with a carefully translated paper, the presenter can communicate quite effectively with a bit of good will, and warm body language, a written submission to a fast moving E-mail list can feel particularly exposing. I am sure this inhibits many valuable contributions.

Despite few drop outs, negative feedback has been useful in another way, particularly as confidence in the list grew, and people risked making contributions themselves. The number of messages rose, and per day became unpredictable. I risked remonstrating with a member with many international links when he complained that he had been away only a few days, and there were 150 E-mails in his letter box, that it was his responsibility to manage his E-mails in an orderly way. But I thought more about it too.

There were advantages for myself, and also for the list, to try to peg messages to a maximum of 3 per day Monday to Friday. This would allow the busiest of international experts to know what they are scanning and to be selective. It would allow me time to think over the weekend. It would allow a mixture of contributions and abstracts of interesting articles from the major psychiatric journals so that we could keep an eye on developments outside as it were as well as among ourselves.

By agreement with the ISPS board, and the local chapters, the invitation to membership has now been extended to any member of a local chapter, or international individual member. A number have joined particularly from eastern Europe and Israel, where chapters of ISPS are in formation. More have come in from Scandinavia and the USA, enriching, rather than disrupting the dynamic, and a further announcement is due on the UK list. Indirectly ISPS-INT may have helped the dynamic towards the formation of a New Zealand chapter with perhaps its own E-mail list, and Australia is to follow.

Numbers have climbed to over 190, with an additional 19 addresses noted by "Yahoo groups" as "bouncing", a strange painless invisible process whereby someone has slipped out of contact because the E-mail address no longer connects.

Particularly gratifying at the time of writing this contribution, was to forward a request for help in Greece, and to receive within 24 hours 4 recommendations from extremely busy internationally-known "experts". This suggests we have been able to win an increase in numbers with a most competitive high signal to noise ratio.

To keep the dynamic between readers and contributors at an appropriate level as moderator, I see myself sometimes as a sort of hopefully educated chat show host, mostly encouraging, sometimes seducing or prodding, to stimulate enough controversy to hold interest, but not so much as to shut down communications, through overt conflict.

Another dynamic is that empirical researchers save their best insights till conferences where they trade and swap their research and consider joint projects. They prefer to scan the literature between conferences. It has therefore probably become useful to forward to the ISPS-INT list, the most interesting abstracts from the electronic table of contents of leading psychiatric journals. Hopefully this brings a new link for even the best connected empirical researcher, while raising the questions for all ISPS members of how these new findings are best integrated with therapy for individual patients.

It helps also to remember the story Rumi told of the elephant many centuries ago.

We are all blind on the internet, groping or palpating a very large elephant. Each on our own cannot describe the beast in front of us, but with perseverance and patience a more comprehensive picture can emerge, of schizophrenia, if that elephant exists, or the various human tendencies to have psychotic experiences, if it does not.

It will also be important to be able to discuss with mutual respect the evidence of efficacy in a whole series of individual cases, with the bigger problem of how to move onto effective services in the field that can meet the needs of tens of millions of people with schizophrenic type illnesses world wide.

While each moderator brings their own intuition and experience, the future of an E-mail list is above all in the hands of the members. As the list grows larger, a process of differentiation needs to occur to promote a more sophisticated level of global networking. It may be that each individual can effectively scan only 3 or 4 lists, and those selectively. We need to have enough flexibility and enough stability. It may be that ISPS can help the formation of chapters in many more countries each with their internet connections. Meanwhile other parallel lists are possible on a world wide basis for those who wish to specialise: on the interface between increasingly dynamic biological and neurological models, on the tendencies within CBT to engage more explicitly with emotions, on the problems of engagement and

delivery of interventions for families, on the specialised understanding of what psychoanalytic interventions may be best for which patients.

Networks, like those of the human brain, and of the human mind, are inherently dynamic. In between symposia, hopefully ISPS will make use of the electronic opportunities to achieve our global aims in a dynamic and creative fashion.

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CHAPT. 19 and 20 PHOTOGRAPHS



Ann L. Silver



*Jan Olav Johannessen and
Brian Martindale*

Establishment of Local ISPS activities

- 19. Europe
- 20 A. United States of America
 - The ISPS-US
- 20 B. Australia
- 20 C. New Zealand
- 20 D. Eastern Asia

19. Europe

Brian Martindale and Jan-Olav Johannessen

Introduction

As can be seen from the list of fourteen International ISPS Symposia, most of the conference activity of the ISPS since its foundation has taken place in Europe with only three symposia taking place outside of its boundaries (two in the USA and a recent symposium in Australia).

We think this accurately reflects the favourable degree to which psychological approaches have been developing within mainstream mental health services in certain parts of some European countries especially the Scandinavian countries that have hosted more than a third of the European ISPS symposia.

As has been already presented in the preceding chapter, it was hoped that by creating appropriate central organisational structures, it would then be possible to create local frameworks or scaffolding within which professionals (and users and carers and administrators) could find ways of creating support to develop and share clinical experience and knowledge of psychological approaches and that effective ways would be found of influencing service development. It may be important to underline that the formal formation of the ISPS society in 1997 occurred at both the nadir of despair of many at the strength of influence of "Decade of the Brain" (The U.S.A. Presidential Proclamation 6158, 1990) with its magical expectations of finding 'the biological cause' and a cure for 'schizophrenia' and at the very same time a growing ascendancy in other geographical areas of reasonably sound experiences of being able to implement psychological therapies as a central component of therapy, whilst still respecting the increasing knowledge from genetic, biological, neuropsychological and pharmacological contributions.

In this chapter, we outline the developments that are taking place in various parts of Europe within ISPS frameworks and links. These are given in alphabetical order. There was a Scandinavian wide ISPS network that held meetings but it has recently been considered that more regular support will come from each country having a network for local meetings, even though it is hoped that there will still be Scandinavian wide ISPS meetings from time to time.

CROATIA

During the early part of the twentieth century, when Freud was developing his momentous insights into the human mind and its development, Croatia was part of the Austrian-Hungarian empire, and its capital was Vienna. The well known psychiatrist and psychoanalyst from Zagreb, Stjepan Bettelheim brought the 'new psychoanalytic science' to Croatia. By the 1930's Zagreb had become the centre for the spread of psychodynamic thinking and therapeutic approaches in South-Eastern Europe. Unfortunately, at that time the psychodynamic approach to psychotic patients was not widely accepted by psychiatric and psychological circles.

In the late 1960's the Zagreb psychiatrist Dr. A. Maletic trained and worked in Chestnut Lodge Hospital in USA and on returning started seminars on the psychotherapy of the psychoses. This marked the beginning of the systematic training of psychodynamically oriented psychiatrists, psychologists and psychiatric nurses in the psychodynamic approach to psychotic patients.

Initially this approach was only with individuals and through therapeutic community approaches in day hospitals. Other psychiatrists and group analysts such as D. Blažević, E. Cividini-Stranic, E. Klain, started training courses in psychodynamic understanding and therapy in the chronic psychiatric hospitals. The 'movement' was spread further by S. Strkalj-Ivezić, B. Restek-Petrović, N. Oresković-Krezler, S. Biočina and many others in the North of Croatia. In the Mediterranean part of the Country there were Lj. Moro and her colleagues in Rijeka region, J. Jelaić and H. Marainko in Pula region, and I. Urlic and his co-workers V. Matijević, M. Vlastelić, S. Pavlović and some others in Split and the region of Dalmatia. Therefore a psychodynamically oriented individual and group

approach to psychotherapy of psychoses had been practiced for more than 30 years in Croatia. In spite of this tradition, the psychodynamic approach remained in the shadow of wide spread pharmacological therapeutic approach.

This has been furthered by S. Strkalj-Ivezic and I. Urlic who have, since 1997, been organising the yearly 'School of Psychotherapy of Psychoses' in the setting of the Inter-University Centre in Dubrovnik. The subtitle of the School is *Towards the comprehensive therapy of psychoses*. During the activity of the School many prominent workers from other countries came to lecture and exchanging their experiences with the participants: from Chestnut Lodge and Austin Riggs in the USA; also from the UK, Italy, Denmark, Greece, Poland, Germany, Austria, Slovenia and Croatia.

ISPS Croatia in collaboration with the IGA Zagreb and Croatian Medical Association and psychiatric professional associations are developing not only the psychodynamic culture in approaching psychotic patients, but associations of family members of psychotic patients, anti-stigma programmes and also research.

DENMARK

Up to now, ISPS activities have been through the networking of the Danish National Schizophrenia project (DNS) in which 16 centres meet twice a year. This network organised some years ago a very successful Nordic ISPS seminar on "Subjectivity and the treatment of psychoses". The presentations (made by: J Parnas, J Cullberg, P Möller, S Levander, K Lehtinen, S Gilbert) were centered around themes such as: 'Phenomenology, the Self and schizophrenia,' 'Subjective experience of the prodromal phase,' 'On the generalisation of psychotic experience,' 'The therapist's subjective experience of the patient's psychotic phenomena,' and 'Subjective perspectives on life, death, and illness in persons with schizophrenia.'

Now we plan to initiate an independent ISPS organisation in Denmark in March 2006, and in relation to that we shall invite persons from the International ISPS to present different topics. Furthermore, we are planning to host the 2009 ISPS congress in Copenhagen.

DUTCH SPEAKING GROUP

An innovatory ISPS network of the Dutch speaking group has drawn together practitioners in Holland and Belgium under the leadership of psychiatrist Jan Leijten together with the group's board members Ludi van Bouwel, Jos de Kroon, Margreet de Pater and Dirk de Wachter

This group has been operating as a society since 2002, calling itself the Netherlands-Flanders ISPS Network. It has held three successful conferences with up to 150 participants, including Johan Cullberg (Sweden) and John Read (New Zealand) as speakers at two conferences. A further meeting has focussed on family approaches to psychosis. The group participated with the Dutch Society for Psychiatry in a symposium on Psychotherapy and Psychosis. These activities have led to the consolidation of the group and have widened the membership.

Recently the right wing government has brought in measures that have greatly restricted the amount of psychotherapy that patients can receive to a maximum of 25 sessions and this has led to a reaction by the group and cooperation with the Dutch Society for Psychiatry in this issue.

FINLAND

The interest in psychological treatment of schizophrenia and other psychoses and in the ISPS activities in Finland has old traditions. It had already begun during the 1950s when three Finnish psychiatrists, Martti Siirala, Kauko Kaila and Allan Johansson, had their psychoanalytic training in Switzerland, led by teachers like Gustav Bally, Medard Boss and Gaetano Benedetti. They also participated in the first ISPS symposia in Lausanne and Zurich. After their return to Finland Siirala and his colleagues founded the Therapeia Foundation in 1958. The training programs established by the Therapeia have had a special emphasis on psychoanalytically oriented individual therapy of schizophrenic patients.

Another group was formed in the Department of Psychiatry at the University of Turku at the end of the 1960s, led by professor Yrjö Alanen and his co-workers Viljo Rökköläinen, Klaus Lehtinen and Jukka Aaltonen. Alanen and his team also organized the IVth ISPS symposium – the first one outside of Switzerland - in Turku 1971.

The Turku approach had a broad psychodynamic basis including both family and individual therapies and establishment of 'psychotherapeutic communities' at the hospital ward. The project led to the establishment of the Finnish 'need adapted approach', and spread to several centres around Finland during the National Schizophrenia Project (years 1981-1987), especially in the establishment of family-centred acute psychosis teams. Later the API project (Acute Psychosis Integrated Treatment 1992-1998, led by Ville Lehtinen) became influential. Jukka Aaltonen and Jaakko Seikkula have been important leaders in the development of flourishing systemic-psychodynamically oriented family therapeutic activities.

The Finnish psychotherapists have participated actively in many ISPS symposia with presentations of their projects and therapy reports. Maybe the domestic activities including various training programs have been a contributory factor in the diminished need to develop a local ISPS organization in Finland. There have been preliminary talks of the establishment of a Finnish ISPS organization but so far no decisive actions have been taken. Still, there has been more active participation in the Inter-Scandinavian activities, esp. the NIPS (Nordic Investigation on Psychotherapy of Schizophrenia) -Project as well as in the symposium the Scandinavian ISPS group arranged in Copenhagen.

FRANCE

France has a rich tradition of clinical and theoretical contributions to the psychology of psychosis and especially well known are the adaptation of ideas from Jacques Lacan into clinical work . There is also a strong tradition of involving psychoanalytical ideas in work with families. There is no organisational structure that link with ISPS but certain individuals have made important contributions to ISPS conferences such as Françoise Devoine, Jean-Max Gaudilliere, Pierre Delion and Didier Houzel. We think it is a matter of time before there are stronger links, though language will be one complicating factor.

GERMANY

Over several decades, there have been a number of German groups with connections with the ISPS and in 1981, the seventh ISPS symposium was held in Heidelberg organised by Helm Stierlin. The latter had a considerable international influence as a result of his creativity in his clinical and theoretical work with families that have a psychotic member.

In more recent years Franz Resch, Professor of Adolescent Psychiatry in Heidelberg became a member of the ISPS Board. He initiated a German wide network during the World Association for Dynamic Psychiatry meeting in Munich in March 2001. The new network organised a symposium on “*Pre-morbid personality development and its impact on the initiation of psychosis*” and a further meeting took place during the congress in connection with the opening of the “Prinzhorn Exhibition” in Heidelberg, September, 16th 2001

In 2002, Resch and his colleagues organised a well attended ISPS conference again in Heidelberg that was linked with a ISPS Board meeting and a number of members of the ISPS Board gave presentations (McGorry, Australia, Johannessen, Norway and Martindale UK.)

ISRAEL

In 2004 and 2005, there was a rapidly growing interest in forming an ISPS network in Israel due to the efforts of Orna Ophir, Shlomo Mendelovitch, Shmuel Kron head of Shalvata mental center and Dr. Ilan Treves who worked in Chestnut Lodge in the late 1980's. They launched the network with a conference in June 2005 that had some 250 participants from all over Israel. It had the enchanting title of “Wonders in the underground. Psychotherapies with people living with schizophrenia.” Ann-Louise Silver was the overseas speaker. Shalom Litman who has been connected with the ISPS for many years also spoke about the nationwide spread of group therapeutic work that facilitated the closure of the long stay hospitals and created a new paradigm. The group intend to have an annual conference and bimonthly meetings.

ITALY

Italians have been very active participants in ISPS conferences especially since the large Italian ISPS symposium held in Turin in 1988, organised by Pier Maria Furlan. The authors of this chapter are very aware of the rich and extensive contributions of clinicians to psychosis throughout Italy using interventions based on psychoanalytic and family systemic approaches as well as their psychosocial revolutions in the organisation of care. Of course the influence of Gaetano Benedetti in many parts of Italy has been extensive. We are hopeful that we will soon hear of networks forming that will link with ISPS that will continue to support these traditions and maintain the

international links. In the last two years Professor Tullio Scrimali from Catania of Sicily, with an emphasis on CBT, has made good links with the ISPS especially through his annual conference, Volcanic Minds, to which a number of members of the ISPS Board have been invited and actively participated introducing the breadth of modalities that ISPS represents.

NORWAY

Norway has hosted two international ISPS symposia: Oslo in 1975 and Stavanger in 2000. The Scandinavian countries have been one of the strongholds for psychological treatment of psychosis, especially as part of the so-called 'need adapted' treatment programs. These are individually designed comprehensive treatment programs, usually based on a psychodynamic understanding and a practical, eclectic therapeutic approach.

ISPS Norway was founded in 2004, as the Scandinavian ISPS was dissolved as a result of the basis of a wish to develop national chapters in the Nordic countries. It's secretariat is situated in Hamar in eastern Norway, where we also have our regular national ISP conferences in January each year.

As well as giving inspiration to our clinical work, these conferences form the basis for the financing of the secretariat. At present we have about 150 members.

POLAND

Professor Yrjö Alanen (Turku, Finland), through his lectures there and translation into Polish of his book on the need-adapted approach to Schizophrenia has been influential in Poland and it is hoped that an ISPS network will soon formed.

RUSSIA

The main seat of ISPS-Russia is in the town of Stavropol, situated close to the Caucasus region in the south of Russia.

Dr. Igor Bylim, chief psychiatrist in the Stavropol region, together with clinical psychologist Alexey Koryoukin, are the driving forces in the ISPS-

Russia. The ISPS-Russia is co-organiser of three yearly national conferences in Russia, together with the Stavropol psychoanalytic society. At present they have about 20 active members.

Representatives from ISPS-Russia have participated at the two last ISPS-international conferences.

SLOVENIA

In 2005 ISPS Slovenia was founded as an organization for the development of clinical work and research on psychotherapeutic approaches for psychotic patients. This followed a two day meeting in Portoroz of about 50 Slovenians. Professor Uria, Dr Ivezic and Dr. Bioaina, our Croatian colleagues were most helpful in the formation of the organisation.

In Slovenia there is a long tradition (going back more than 40 years), of group analytic work with patients with schizophrenia. This was developed by Dr Franc Peternel, a member of the Institute of Group Analysis (London) who practised as a psychiatrist at the Ljubljana University Psychiatric Hospital.

Many Slovenian psychiatrists who are doing individual and group work with patients with psychosis have attended the Dubrovnik School of Psychotherapy for psychoses (*see ISPS Croatia in this chapter*) and a most important clinical and scientific collaboration has developed. Further ISPS Slovenia meetings are planned for late 2005 and 2006.

SPAIN

Madrid, the host city for the 15th ISPS International Congress, coinciding with the 50th anniversary of the founding of ISPS, has for eleven years been hosting an annual two day conference focusing especially on the global approaches to the psychoses and schizophrenia and psychotherapeutic and psychosocial treatments which could help those persons.

Dr. Manuel González de Chávez and his colleagues have been the driving force behind these events that have drawn participants from the whole of Spain

leading to an attendance of up to eight hundred. A host of international experts including ISPS members have contributed amongst the main speakers ensuring that our Spanish colleagues are well informed about developments around the world and this has facilitated the development of Spanish approaches and psychotherapeutic programmes.

Plans are in advanced stage to ensure that following the 2006 international ISPS conference, the existing Spanish ISPS network will develop considerably and that the conference will also encourage other Spanish speaking countries and Portugal to form their own networks.

SWEDEN

ISPS-Sweden started in Stockholm in 2002. At the beginning the enthusiasm was considerable and we started by having two meetings a year, a model we have held on to.

Our initial aim was to discuss the different factors that we considered important for the improvement of the care and treatment of psychotic patients. Our aim was to write our own guidelines, as we were disappointed with those that were to be presented by the Ministry of Health. We wanted more emphasis on psychological methods, a change of the psychiatric organisation and an increased awareness of the patient's subjective understanding of his or her problems.

However, the number of active participants decreased, and the general opinion was that we needed more time for social interaction and more contact with interested people outside the association. So in the autumn of 2004 we had a big open meeting with Jaakko Seikkula of Finland as an invited speaker. In the spring of 2005 the members met with John Read from New Zealand for a whole day to share his experience, and some reporters were invited to interview him in order to reach a wider audience.

For the future we would like some programs to include actors, authors or painters - former patients and others - who try to convey aspects of their experience of psychosis.

SWITZERLAND

Switzerland is the home country of our ISPS founders, Gaetano Benedetti and Christian Müller. Benedetti's important writings have been translated into German and Italian and a second book will appear in English in time for the Madrid conference and the 50th anniversary of the founding of ISPS which this book commemorates. Since 1956, Benedetti has been professor at the University of Basel, where he has trained and supervised many generations of psychoanalysts and psychoanalytical psychotherapists. In 1969 the then newly founded "Centro di Studi die Psicologia Clinica e Psicoterapia" chose him and Professor Cremerius as their first and foremost teachers. (In the following decades he taught in Basel and Milan in parallel). In the course of the years the Milan institute became a centre of teaching and research on the psychopathology and psychoanalytic psychotherapy of psychoses. Publications of this Institute are testimony of this work. In 1972 Benedetti received the "Frieda Fromm-Reichmann-Prize" in Dallas, USA and the "Jakob Burckhardt-Prize" in Basel 1981 for his scientific work. In 1990/91 he was proposed by the University of Basel for the Nobel-Prize.

Since the development of the ISPS into a formal organisation in 1997, the main link with the ISPS has been through the lively Swiss network of the EFPP (European Federation of Psychoanalytic Psychotherapy in the Public Sector <http://www.efpp.org/>) which has sections devoted to child, adolescent, group and individual adult work and which should soon have a family section. Many of our Swiss colleagues in the EFPP work with people with psychosis. As well as Benedetti's work and influence, particularly noteworthy is the work of ISPS member Julia Pestalozzi who has contributed to the theory of disturbances in symbol formation.(ref. International Journal of Psychoanalysis) and to the role of the body image, e.g. dysmorphophobia in psychotic states.

As yet professionals from other theoretical modalities have not formed networks.

UNITED KINGDOM

The UK has an extensive ISPS network of some 400 members. Hosting the 12th International ISPS Symposium in 1997 in London was a tremendous impetus to implementing the psychological approaches to psychosis and to

forming an ISPS UK framework to further develop interest, skills and their implementation. Full details of the developments of the ISPS UK network and its activities are contained in chapter devoted to the 12th ISPS symposium, 'Building Bridges'.

COMMENTARY

The decision to actively encourage the formation of ISPS networks in countries, cities or regions followed on from the major change in focus of the ISPS that was embedded in the creation of a constitution in 1997. The summaries contained in this chapter indicate how much progress has been made in a short time underlining the growing realisation that in order to change practice it was going to be necessary for interested clinicians to be in regular local contact for support and education and to determine a local developmental plan. The foundations laid augurs well for the future of the psychological therapies in psychosis in the countries mentioned. Although it is of course hoped that the growth of such therapies will proceed apace without the need for an organisation such as the ISPS, it would be naive to assume this. In fact not only will it be necessary for such groups to gather professionals, it will also be necessary to ensure that at different hierarchies in the mental health services there is adequate representation arguing the need for such services and addressing obstacles to their provision. We anticipate that in the next decade there will be a continuing growth of ISPS groups, hopefully with many of them involving users, families and carers and that some groups will be active in creating the conditions for policy change and implementation at local and national levels.

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20 A United States of America The ISPS-US: A Personal Account

Ann-Louise S. Silver

Introduction

ISPS-US held its seventh annual meeting in November, 2005. Our membership is approaching 300. We are a young group, gradually growing in numbers and cohesiveness. In the past, people came to me at our meetings, expressing how positively they felt towards the various presentation. Now, many say, "I love ISPS!" We have a recipe for success: spicy talks on efforts to start new Soteria Houses and to renew programs, talks on research especially supporting humanistic approaches, heady theoretical discussions, but the centerpieces, surrounded by case presentations, are the talks given by recovered patients who tell us about their current projects. This year we heard from Joanne Greenberg, Catherine Penney, and Will Hall.

We are very proud of the part we played leading to the removal of the onerous recommendations against individual and family psychodynamic therapy for patients with schizophrenia, that were dropped from the Patient Outcome Research Team's revised report. (Lehman et al., 1998 & 2004) The PORT no longer says "psychotherapy aimed at understanding unconscious drives or getting at the psychological roots of schizophrenia is never appropriate." The authors admit that this was a "level C" recommendation, based on expert opinion, not hard data. They now say that they omitted comment on this modality since it is *no longer practiced*, just as insulin coma treatment is a thing of the past! We are now striving to see a positive statement regarding psychodynamic therapy of schizophrenia included in a future edition of the PORT. I will discuss our latest project in the conclusion of this chapter.

As president of ISPS-US throughout this early phase, I love our group's dedication and scholarship. Our lively and informative listserve continues to

inspire its readers and contributors. It is open to interested non-members for a three-month introductory period: write to our executive director, Karen Stern, at contact@isps-us.org. Our two-year-old website, www.isps-us.org contains postings by our newsletter editor, Brian Koehler, that are required reading in a growing number of training programs. We are an official non-profit organization, battling against bio-reductionism and against the pharmaceutical industry's repeated but unsupported statement, "Schizophrenia is a brain disease." We see psychoses as disorders of profound anxiety and chronic stress. When someone is beleaguered and bewildered, he or she needs someone who is calmer and who is willing to stand by and try to help understand. (Alanen 1986, 1997; Ciompi, 1988; Fromm-Reichmann, 1950; Havens, 1976)

We fully support ISPS whose scope of treatments studied and supported has widened well beyond psychoanalysis. We aim to foster psychosocial treatments –to keep the individual sufferer known as a unique human being, with strengths as well as weaknesses. Mind is not merely an epiphenomenon of brain activity; illness does not result from bad genes. I believe we should not rely on monetary support from the pharmaceutical industry which has turned our journals into info-mercials and some say has turned the psychiatric residency training programs in the U.S. into training in selling pharmaceuticals. (Angell, 2000 a & b; Bodenheimer, 2000; Healy, 2003, a & b) I recommend Robert Whitaker's book, *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. It was runner-up for a Pulitzer Prize. Whitaker was the keynoter at the ISPS-US fourth annual meeting in New York City, in 2002. He is a vibrant speaker and a careful scholar.

ISPS-US was founded on October 10, 1998 by David Feinsilver, M.D. a long-time Chestnut Lodge medical staff member and chair of its symposium committee. (Feinsilver, 1986) Quoting from my "Letter from the President" in our first ISPS-US Newsletter, Summer, 1999, David "saw the Saturday after Chestnut Lodge's yearly symposium as a logical time, the Lodge the logical place for the birth of our organization." He chaired the ISPS symposium in Washington in 1994, discussed in a separate chapter of this book. By October of 1998, he knew that he struggled with advancing colonic cancer. He gathered a group of thirteen interested Lodge staff members to discuss the importance of launching a United States Chapter of ISPS. We all saw the merit of this idea. He later urged me to take on the initial leadership; at first I demurred. A group in Washington soon formed and joined with a study group in New York City, headed by Brian Koehler with Julie Kipp. Their group

had been meeting monthly for about five years; Brian and Julie were regular attendees of the yearly Lodge symposia.

The annual meetings of ISPS-US

By October of 1999, we were able to hold our first annual meeting, at the Washington School of Psychiatry, co-chaired by Christine Lynn, M.S.W. and Allen Kirk, M.D., "Creating Space for the Unaccommodated Self in Psychotic States." Julie Kipp, CSW, Christine Lynn, MSW, Marvin Skolnik, MD and Virginia Hendrickson, MSW presented papers. We met the day after the Chestnut Lodge Symposium which was dedicated to David Feinsilver's memory. Paul Carroll, Ph.D. wrote an eloquent summary of the meeting for our fall, 1999 ISPS-US Newsletter, Vol. #1, Issue #2, which is posted at www.isps.org and www.isps-us.org. Even in those early days, we began talking about launching a journal, and about establishing a training and study center for the treatment of psychoses. We still hope to actualize these large goals. Julie Kipp, LCSW served as both secretary and treasurer. Joel Kanter, M.S.W. established our ISPS-US listserve in 1999. At this point we had branches in Washington and New York. As the organization grew, we divided the tasks of secretary and treasurer. Julie Kipp continues as our secretary. Barbara Cristy, LCSW, took over as treasurer, to be succeeded in 2005 by Julie Wolter, Psy.D.

David Feinsilver endowed a fund for a travel scholarship for the person submitting the best paper on research on the psychotherapeutic treatment of the severely disturbed; this would fund someone presenting who otherwise would not be able to afford to attend. There have been two recipients, Konstantia Zgantzouri, of Crete, Greece, who presented at June, 2000 ISPS meeting in Stavanger, and Ishita Sanyal of Kolkata, India who presented at the Melbourne 2003 ISPS meeting. Various members of the ISPS-US board have served as reviewers.

The following meeting "Creating Space to Talk to Patients", October 7, 2000, also took place at the Washington School of Psychiatry. The morning's presentations were by Wayne Fenton, MD on the history of U.S. asylums, by me on the history of psychoanalysis and psychosis in the U.S., followed by a beautiful case presentation by Betty Oakes, PhD, of Austen Riggs. The afternoon's program was a quasi debate with Anthony Lehman, MD, on the issue of the PORT Project. Lacanian philosopher Wilfried Ver Eecke, PhD presented a well-crafted

challenge to the PORT recommendations against individual and family psychodynamic therapy for schizophrenia, even in combination with medication. (Ver Eecke, 2003) William Gottdiener, PhD presented his meta-analysis demonstrating the benefits of individual psychotherapy for schizophrenic patients. (Gottdiener & Haslam, 2002; Gottdiener, 2003) At the close of the meeting, we learned from Wayne Fenton that a revision of the PORT Report was being planned; he added that he was pessimistic that we could influence it. The group, however, eagerly pursued the challenge.

I proposed to the ISPS board that an international task force be formed challenging the PORT. The board responded promptly. Colin Ross, MD and William Gottdiener, PhD represented the U.S. on the distinguished ISPS Task Force on the PORT, chaired by Tor K. Larsen, MD, PhD. (Larsen, 2003). Meanwhile, Douglas Ingrahm, M.D. was soon to assume his new responsibilities as editor of the Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry. He invited me to serve as guest editor of an issue devoted to this important debate, knowing that ISPS did not yet have its own journal. I invited Tor K. Larsen to serve as co-editor. The Journal issue, "*The schizophrenic person and the benefits of the psychotherapies—Seeking a PORT in the storm* (Silver & Larsen, 2003)" appeared in the spring of 2003, as Volume 31, Number 1. It now serves as required reading in at least five college and graduate school classes. Meanwhile, I was invited to join the 100 experts contributing to the first revision of the PORT. On receiving the document I was thrilled to see that the onerous Recommendations 22 and 26 had been deleted.

Our group contributed to other meetings as well. ISPS-US under David Garfield, MD's leadership presented a well-received panel at the American Psychiatric Association's 2000 Institute on Psychiatric Services, in Philadelphia, "Out of psychosis and into life: Psychotherapy in the field." Presenters included Joel Kanter, MSW, Julie Kipp, MSW, Mary Moller, MSN, and Michael Robbins, MD, with Wayne Fenton, MD discussant. During 2000, ISPS-US members presented papers at the meeting of the International Federation for Psychoanalytic Education (IFPE) held in Chicago, on the theme of "Psychoanalysis and Psychosis." ISPS-US became an affiliate member of IFPE, (www.ifpe.org); an ISPS-US-Chicago branch formed at the IFPE meeting. In 2003, we presented a panel at the winter meeting of the American Academy of Psychoanalysis and Dynamic Psychiatry in Chapel Hill, North Carolina, which I chaired, "Beyond medication: Remembering the spirit and mind of the psychotic patient." Presenters included Shelley Alhanati, Ph.D.,

Clare Mundell, Ph.D., Garry Prouty, D. Sc. and in absentia, Brian Koehler, Ph.D.. There were many young people in the audience who listened with rapt attention, and who commented that all the material was both new and inspiring. It is clear that we need to organize a system whereby our membership can speak at various mental health training programs.

Our third meeting in 2001, also at the Washington School of Psychiatry, in 2001, "Celebrating our Dialogue" honored Maurice Green, M.D. Eight people presented or served as discussants. About 60 people attended. Speakers included Harold Stern, PhD, Andrew Martin, PsyD, Clare Mundell, PhD, Brian Koehler, PhD, Maurice Green, MD, Michael Robbins, MD, Philip Alex, PhD and Sue von Baeyer, PhD. We enjoyed our growing comfort with each other.

Our fourth meeting in 2002 was held at the William Alanson White Institute in New York City and was chaired by Brian Koehler. About 75 attended. We held the meeting on both Saturday and Sunday, and thirteen people presented papers. We honored Bertram Karon, (Karon and VandenBos, 1981; Karon 2003) who presented an evocative paper. Harold Stern, PhD presented a paper, and announced his plan to launch ISPS-US-Philadelphia. At our business meeting, we adopted Articles of Incorporation and a constitution.

Our fifth meeting in 2003, "The mind behind the brain" was held at the Thomas Jefferson Medical University in Philadelphia and was chaired by Harold Stern, PhD. John Strauss, MD served as keynoter, "Subjectivity in psychiatry: How can we do better?" In many ways, this has become the theme for our two subsequent meetings. We honored Anni Bergman, PhD in absentia, and watched a compelling documentary on her successful treatment of an autistic girl. We mourned the passing of Victoria Conn, R.N., who had been the co-chair of this meeting. Again, we met for two days, and heard from 27 speakers, and for the first time we held two simultaneous tracks. The meeting closed with a lively and provocative panel, the outcome of which was the launching of the ISPS-US e-seminar on psychoanalysis and psychosis, moderated by Michael Robbins, M.D. Karen Stern, M.A had been such a huge help in organizing this meeting that we then hired her as our Executive Director.

Our sixth meeting in 2004 was held at Chicago's Institute for Psychoanalysis. Our keynoter was Leston Havens. (1976, 1986) We heard from twenty-six presenters, including overseas speakers Chris Burford from London, Danielle Bergeron from Quebec, and Francoise Davoine and Jean-Max

Gaudilliere from Paris. We explored the various ways psychosis is understood by individuals from a variety of disciplines and theoretical lenses. This meeting had four tracks and was the first to be held at a hotel. Each day began with a plenary case presentation which really galvanized the group. Jessica Wall presented her work with an autistic adolescent girl, and Greg Rosen presented his work with an adult schizophrenic woman.

Our seventh meeting was held in Boston and chaired by Ron Abramson, MD. Our keynoter was George Atwood, Ph.D. We explored various approaches to understanding how people with psychoses experience their subjective personal universes. The experience of every patient and therapist is valid according to its own terms. Next year, we will meet in Los Angeles, celebrating the formation of the ISPS-US-Southern California and the expansion of ISPS-US-Northern California. Our theme will be "Trauma and Psychosis."

We now have branches (ordered chronologically) in Washington, New York City, Northern California, Chicago, Philadelphia, Michigan, New England, and Southern California. Each branch is financially independent of the United States Chapter.

A personal history

When we talk about the history of a group, we take for granted the histories of its members. We assume a basic commonality and we respect each others' privacy. However, a unifying principle of ISPS-US is its commitment to phenomenology, the close study of the events in the life of a person, and the meaning that person gives to these events. One could say we are following in the footsteps of Adolf Meyer. (Lief, 1948) Tim Calton, a Lecturer in Psychiatry at the University of Nottingham presented his findings on the strong representation of case reports (over 1/3 of all presentations) at our ISPS symposia; but he warned that in recent years the percent has dropped steadily. Meanwhile, at schizophrenia research conventions, a mere 2% of papers highlight the particulars from an individual's life. (Calton, in this book).

As Gertrude Stein wrote,

"Sometime then there will be a history of every one of every man and every woman from their beginning to their ending. Sometime there will

be a history of every one and every kind of them and more and more then every one will understand it, how every one is connected with every one in the kind of being they have in them which makes of each one one of their kind of them. More and more then this will be a history of every kind and the way one kind is connected with the other kind of them and the many ways one can think of every kind of men and women as one more and more knows them as their nature is in them and comes out of them in the repeating that is more and more all of them.” Gertrude Stein, *The Making of Americans*, p. 126.

But while we have many papers illustrating their message with a case presentation or some vignettes, I know very little about the lives of most of the members of ISPS-US beyond aspects of their careers. We play our personal cards close to our professional vests, learning much about our close colleagues when we read their obituaries. Personal accounts belong with our analysts, therapists, and perhaps family members and close friends. But it is nobody else’s business. And yet the members of ISPS-US have chosen career paths that differ from the mainstream of their professional cohorts. We are a strange lot; we stay with our patients over the long haul, through frustrating and often terrifying phases, struggling to form relationships with people who have pulled away into their own tortured worlds. We fight a strange battle repeatedly. When we succeed, we are told that we have not cured “a schizophrenic,” but that the original diagnosis was wrong. Our colleagues look to the heavens when we challenge the general belief that “schizophrenia is a brain disease.” Again, quoting Gertrude Stein,

“Disillusionment in living is the finding out nobody agrees with you not those that are and were fighting with you. Disillusionment in living is the finding out nobody agrees with you not those that are fighting for you. Complete disillusionment is when you realize that no one can for they can’t change. The amount they agree is important to you until the amount they do not agree with you is completely realized by you. Then you say you will write for yourself and strangers, you will be for yourself and strangers and this then makes an old man or an old woman of you.” Gertrude Stein, *The Making of Americans*, p. 282.

Having an organization like ISPS-US thus keeps us young. We tend to support each other, saying “yes” when the larger mental health community shouts a resounding “no.” (This assertion minimizes the divisions within ISPS-US, just as those outside Chestnut Lodge assumed a strong

philosophic unity, when actually big divisions existed there as well.) How have we gotten ourselves into such a place of stubbornness? My guess is that we each made this decision at a very early age. Frieda Fromm-Reichmann, who died in 1957, one year before the ISPS was born, said, "I was born to be a psychiatrist because beginning at three, I knew all the secrets in the family and I took care not to disappoint my parents." (Silver, *Psychoanalysis and Psychosis*, p. 470).

My story (which I hadn't yet shared with the ISPS-US group) begins with my mother, as all personal accounts usually do. She was born in Warsaw. Her father came to the U.S. when she was two years old; he worked in New York City's Lower East Side garment district. When my mother was four, she came to the U.S. in steerage, along with her mother, Frieda, and her older brother, Ben, on the last ship bringing immigrants at the start of World War I. The voyage was stormy; her mother was severely seasick; my mother thought she would die; her brother ran around the ship, making friends with children on deck. My mother never forgave him for abandoning them. My grandmother later developed a thriving dressmaking business. She could sew a dress from sketches she made of dresses displayed in the windows of Saks Fifth Avenue. My mother went on to be first in her class at a huge and very competitive public high school, and then began at City College. But something happened, and she did not complete the first semester nor did she return, but worked for twelve years as a registrar at the Joint Diseases Hospital.

She met my father at an adult camp in the Catskills, where my father was the camp doctor. He was a public health physician. They married and moved away from their families to Syracuse, New York where I was born. Among my father's duties as a health officer was performing lumbar punctures on children suspected of having contracted polio. He dreaded infecting his own children. He gowned up in surgical attire and a mask before coming into the house, then showered before greeting us. Such a profound joy and relief swept through our family when Jonas Salk announced discovery of the polio vaccine, when I was about nine years old.

When I was four, we had moved to Albany, the state capital, when my father was promoted. This was shortly after the world learned about the Holocaust. My grandmother had been one of nine children. One brother had immigrated to Argentina; the rest went to Russia and were killed. It was only recently, visiting the Holocaust Memorial in Israel that I suddenly realized that it

wasn't just the seven siblings who died, but their spouses, children, the children's spouses and their children. They probably numbered between fifty and one hundred people. My lack of acknowledgement of their very existences left me flooded with guilt and grief, and I realized that I, too, have a form of holocaust survivor syndrome, a workaholic trying to live for those who were lost or were never born. My mother suffered more intensely but privately; her mother had raised \$1 million in war bonds, hoping this would help her family. Helping the beleaguered who live in a psychotic world seems my logical career sub-specialty.

Against my mother's strong opposition, my father contracted to share ownership of a two-family house with a colleague from the health department, someone who would fill in for his older brother. We lived on the second floor, the other family on the first floor. My mother had wanted a single family home – even a tiny cottage. She became irritable, exploding at me, and I became provocative. Once, she yelled at me and as she left my room, I stuck out my tongue – I was sure her back was turned. She spun around and spanked me. "I have eyes in the back of my head. I saw what you did." As a four-year-old, I believed her, even though I never got a glimpse of those extra eyes. But I knew she was terribly perceptive. She often said, "I know you better than you know yourself," and her observations seemed to prove it. I wanted to be able to see the world as she did. I tried very hard to imagine seeing through her eyes, and in an instant when I felt like I was succeeding, I experienced getting sucked inside her skull. I drew back from this exercise in terror that I might get stuck in there forever.

The family tension increased over the next years. The downstairs parents chain-smoked. The father asked my father to write him prescriptions for barbiturates; my father refused. My mother could hear the two daughters crying for long periods at night – the parents were too drugged to hear them. She became terrified that they would set the house on fire, smoking in bed. She developed severe insomnia which only made her more irritable. She claimed she could listen at the wall and hear the downstairs couple plotting to take over the entire house and throw us out. I listened at the wall and heard nothing. I was about twelve. I read Freud's Introductory Lectures, trying to figure out what kind of paranoid my mother was. My father was in analysis with Clinton P. McCord, who had been analyzed by Freud. McCord had made the famous slip of the pen when paying for the first month of analytic sessions, "Pay to the order of Sigmund Fraud." McCord and his wife Alma organized the Albany Psychoanalytic Study Group, whose members were physicians from various specialties. They rotated

homes for the monthly meetings. I was officially allowed to eavesdrop, sitting behind the chair that would one day be my analytic chair.

When my mother's insomnia worsened, my father arranged a consultation for her with Dr. McCord. I fervently hoped she would be treated. (I wasn't making any progress with her at all.) She came home from that consultation exultant. McCord said she had made more progress in one session than most people made in years. She had figured out that she was not fundamentally fearful that the downstairs neighbors would set the house on fire, but was consumed with guilt over a fire she had inadvertently started in her family's apartment when she was seven. She had gone into her mother's sewing room looking for something and had turned on the light, not realizing that there was an iron plugged into the same socket. The fire was easily extinguished. Nobody was hurt, but the experience scarred her.

Dr. McCord let her feel his biceps. She felt honored. This interaction still puzzles me. I was in despair that he had congratulated her and sent her away. She didn't even feel deprived, but even felt rewarded by this strange gesture. I knew that this one session couldn't resolve the depth of difficulties. Perhaps my destiny was sealed that day, and I've had no real choice but to treat patients others would call "unanalyzable" and stubbornly stay with them for as long as it takes. In my psychiatric residency, we were assigned Fromm-Reichmann's posthumous paper, "Loneliness." I knew I needed to learn everything she had to teach. I went to a Chestnut Lodge symposium, where Harold Searles delivered his paper, "Unconscious processes in relation to the environmental crisis." He received a standing ovation, and I knew I'd found my future analyst.

When I began work at Chestnut Lodge four years later, I felt immediately at home, and this was not a cozy feeling. The first day on one of the units I saw a young woman who looked a lot like me, with the same frizzy black hair – she was staring ahead vacantly. I felt like I was looking at myself in a mirror, or looking at my crazy self. My mother died during my first year at the Lodge, her repeated advice to me having been, "Don't get too involved with your patients." I don't think she meant sexually, but emotionally: don't absorb their craziness. Don't fall into their skulls and end up seeing the world through their eyes. Maintain your boundaries. I don't think she ever would have earned a diagnosis of schizophrenia.

It's only now, on writing this, that I see a fundamental connection between my mother's abhorrence and dread of the downstairs neighbors' dependency

on sleeping pills and my own sense of despair over the profession's over-reliance on the various so-called "anti-psychotic" medications, medicines that work primarily by putting the limbic system to sleep as it were, dulling salience, or the ability to respond emotionally to ongoing experiences, whether internal or external. (Kapur, 2002, 2003)

At Chestnut Lodge, in the 1980s, some of the women on the medical staff formed a study group on working with potentially violent patients. We began with a literature review, and then moved to an autobiographic phase which we called the "what is a nice girl like you doing in a place like this?" phase. We took turns telling aspects of our life stories. We all started by talking about our mothers. Our backgrounds were very diverse. The only commonality we found was that we all considered our mothers very depressed. One had been suicidal. We all felt that our mothers' difficulties formed a large motivating factor in our career paths. We presented our findings at a Lodge symposium, but never published. (LaVia, D. et al. 1986)

A philosophy of ISPS-US

The charismatic Gaetano Benedetti, (Benedetti, 1987, 1988, 1993) co-founder of ISPS, was born in 1920. He comes from a family with a proud and long scientific tradition. He worked for ten years with Manfred Bleuler, and has been a professor of psychiatry in Zurich, Rome and Basel. He has been awarded many honors, has published about 400 papers and over 20 books. He has spoken in over 100 international conferences in Europe, North America and Asia. While stressing the value of the triennial meetings, he says [unpublished] that more vital are the ongoing small groups within institutions, where colleagues can discuss their preverbal communication experiences, bringing the colleagues closer to a group therapeutic symbiosis. "...if the therapist manages to overcome the fear of symbiosis, then the work is half done. Of course the resistance of the patient is still to be overcome, which is impossible sometimes..."

This fear of symbiosis was what I had dreaded when I tried at age four literally to see the world through my mother's eyes. Now, I realize that we develop theory in part to maintain our personal boundaries, armoring ourselves in theories that allow us to pull back from the immediacy of therapeutic symbiosis, to generalize as if disembodied, hovering above the therapeutic dyad, observing it like a scientist viewing an organism through a

microscope. John Strauss, who was the keynote speaker at the 5th annual ISPS-US meeting, asks, “In this difficult and fascinating field which ought to be a human science, how do we deal with being scientific about humans, how do we deal with subjectivity and objectivity at the same time?” We professionals use theory to guard ourselves from over-identification with our patients. We can draw back and think about their dynamics when we resonate with their fragmentation and feel that we ourselves might shatter. A patient once said to me, from his cold wet sheet pack, that he was a comet – a cluster of hunks of ice held in fragile connection by each other’s gravitational pull. He warned me not to get too close to him, or I might become a comet too, and what good would one comet be to another?

It was not until the 1994 meeting in Washington that a formal organization was finally formed, thanks to the efforts of Chestnut Lodge’s David Feinsilver and others on the ISPS board. David founded ISPS-US in October 1998, as he struggled with the final stages of colonic cancer. The mission of ISPS is to promote the appropriate use of psychotherapy and psychological treatments for persons with schizophrenias and other psychoses, to promote the integration of psychological treatments in treatment plans and comprehensive treatment for them, to promote the appropriate use of psychological understanding and psychotherapeutic approaches in all phases of the disorders including both early in the onset and in longer lasting disorders and to promote research into individual, family, group psychological therapies, preventive measures and other psychosocial programs for those with psychotic disorders. We support treatments that include individual, family, group and network approaches and treatment methods that are derived from psychoanalysis, cognitive-behavioral, systemic and psycho-educational approaches. We advance education, training and knowledge of mental health professionals in the psychological therapies and psychosocial interventions in the treatment and prevention of psychotic mental disorders for the public benefit regardless of race, religion, gender or socio-economic status. Reflecting the large umbrella, the name of the group enlarged also, moving from the International Symposia for the Psychotherapy of Schizophrenia to the International Society for the Psychological treatments of the Schizophrenias and other psychoses – still keeping the initials ISPS. But there is a consensus that this organizational name is just too long and awkward. But what this new name might be is not yet clear. As concern grows that the very name “schizophrenia” is outmoded and pejorative, connoting an incurable brain disease, we may decide to relinquish the ISPS initials. And there is tension between the psychoanalytic

contingent and the others; are the psychoanalysts trying to pull the group into the past, are we obstructionists, elitists? The group is open to everyone, mental health professionals and others in the mental health field, patients or consumers and their families and friends, and all interested others. We are not interested only in the treatment of psychosis, but in all aspects of understanding it.

The Melbourne 2003 meeting seemed centered around the debate “Can psychological and pharmacological approaches be integrated in the treatment of schizophrenia?” I participated on the “con” side of the debate, along with John Read (2001, 2003, 2004) and Richard Bentall (1990, 2003). I thought we won a clear victory over enormous odds, but the moderator declared the event a draw. Wayne Fenton (my friend and co-worker at Chestnut Lodge – our fathers had worked together at the New York State Department of Health decades earlier) represented the “pro” side of the debate. On arriving at the microphone, he joked with the audience saying, “I wish I were as sure about *something* as Dr. Silver seems to be about *everything*.” The audience responded with a low “ooh” that seemed to me a polite booing. My remarks do not represent an official viewpoint of ISPS-US although many in that group agree with me; they are posted at the ISPS website, www.isps.org. I believe that this debate will be with us for decades to come. We stand for the humane and optimistic treatment of psychosis, one person at a time.

ISPS-US, now in its seventh year. Our growth parallels that of ISPS itself. It has been invigorated by our very active listserve. We fought and partially won a big battle regarding the American Psychiatric Association's guidelines for the treatment of schizophrenia which drew from the Patient Outcome Research Team's or PORT's recommendations. Recommendations 22 and 26 in the first version recommended against psychodynamic treatment even in combination with medication, and recommended against psychodynamic family therapy. The National Alliance for the Mentally Ill quoted these recommendations prominently in their literature to families. Through our annual meetings, we believe we were instrumental in the dropping of those two onerous recommendations from the second issue of the PORT Report. However, we will not be satisfied until the PORT writes in *favor* of the kind of work we do. We are organizing a clinical survey of our 300 members, which will be the foundation for a research project which should yet again demonstrate the value of getting to know the patients we treat. And we are working on a text book written by members of ISPS-US, edited by David

Garfield who organized and headed our ISPS-US-Chicago branch and who chaired our very successful 6th annual meeting there. We want to conduct a research study in which we compare the work in clinics that are infused with this phenomenological energy with those that are struggling to be maximally efficient. We want to look at how the patients are doing, how they feel about their treatment, and we want to see how the staff feels, and if the longevity of employment at those clinics becomes significantly different. But fundamentally, we want to see a resurgence of dedication to the multitude of individuals struggling with psychotic disorders, bringing them need-specific treatment (Alanen, et al., 1986; Alanen, 1997).

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In early 1990s in Australia, The National Mental Health Strategy was launched in Australia as a joint initiative of the Federal, five State and two Territory Governments (Australian Health Ministers, 1992). The Strategy set policy directions and priorities for mental health until mid-1998. The main thrust of the Strategy included an expansion of community-based, case-management sector of mental health services and reduced reliance on inpatient services. These policy developments were refined by further iterations of the plan in the late 1990s and beyond (Australian Health Ministers, 1998; 2003). Despite these policy commitments a national prevalence surveys of people diagnosed with psychotic disorders revealed that less than 40% of individuals with psychotic disorders reported receiving counselling or any form of psychotherapy over the previous year (Jablensky et al., 2000). Not surprisingly, this evidence provided a basis for cogent arguments for a redistribution in Australia of mental resources for the treatment of psychosis towards psychosocial treatments and community supports (Neil, Lewin, & Carr, 2003).

Unfortunately, there is no evidence that the redistribution will be underway any time soon. In late 2005 the peak body representing carers and consumers of mental health care, The National Mental Health Council of Australia, placed the human experience behind this statistic on the centre stage of the national health debate with the launch of their report into the state of mental health care. The title of the report is an apt summary of submissions from across all states and territories: *Not for service: Experiences of injustice and despair in mental health care in Australia* (Mental Health Council of Australia, 2005).

At the last international ISPS conference in Melbourne, in September 2003, a meeting was held with the aim of developing an Australasian ISPS network. No doubt many at this meeting were motivated by a working knowledge of the poor access to the full range of treatment options. After the meeting, it became clearer that two networks, in New Zealand and Australia, would evolve with perhaps varying but overlapping priorities.

With support from ORYGEN Youth Health for a secretariat, Helen Krstev, Eoin Killackey and John Gleeson communicated with colleagues around the country to form an initial core working group with links to public sector mental health services. The initial core working group consists of representatives from Victoria (Helen Krstev, Eoin Killackey and John Gleeson), New South Wales (Simon Jakes), Queensland (Sally Plever), South Australia (Harry Hustig) and Western Australia (Tracey Harrison). This geographical representation is particularly critical in Australia where there are significant variations in mental health services across the states and territories. The group have met regularly via teleconference, and have agreed that ISPS Australia would have an important role in promoting psychological interventions throughout the Australian public mental health sector. ISPS Australia would be particularly motivated to support efforts in relation to improved access to a broader array of interventions by providing an additional focal point for clinicians to join with carers and consumer groups to promote this urgent agenda, with the backing of ISPS international. The group has also discussed the value the network would provide in supporting the workforce committed to psychosocial treatments. Already, approximately 30 professionals have expressed interest in joining the network even before a call for membership has been launched.

The group has agreed that the main tasks for the establishment of the network include:

- Formally registering as an association
- Launching the new network and promoting membership
- Establishing and maintaining a simple ISPS Australia web page and newsletters which would be linked to the International site
- Planning an initial Australian ISPS conference in 2006, as a satellite meeting attached to a larger conference in the first instance.

It is anticipated that as the network is launched in 2006 it will provide an active voice in promoting access to psychosocial treatments in Australia and an important additional resource for clinicians.

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Although New Zealanders had been individual members of ISPS for some years, the first move towards forming a national ISPS group followed the 2003 Symposium in Melbourne. We invited three of the international speakers at Melbourne, Richard Bentall and Tony Morrison (UK) and Courtenay Harding (USA), to New Zealand to be keynote speakers in our 'Psychology of Psychosis' conference, organised jointly with the Psychology Department of the University of Auckland, immediately after the Melbourne event. We were delighted to find nearly 200 people, from a range of disciplines, including users of mental health services, showed up. We decided, therefore, to make this an annual event – renamed, in order to broaden the appeal and focus, to 'Making Sense of Psychosis'. At the second conference, in 2004, we were again excited that the same number attended the two day event, at which our keynote speaker was Ron Coleman from the hearing voices movement in the UK. It was formally agreed, at this conference, to establish a New Zealand branch of ISPS. A steering group of five was elected, with the professions of psychiatry, psychology and occupational therapy represented. We subsequently extended the group to include a nurse and a service user.

During 2005 we have worked on the time-consuming tasks of registering as a formal organisation with our government, establishing a bank account and so forth. Everyone registering for the third annual conference (October 2005) automatically became a member. Our keynote speaker for 2005 was Dr Colin Ross (USA), author of 'Schizophrenia: Innovations in Diagnosis and Treatment' (2004).

Six New Zealanders contributed to 'Models of Madness' the first in the current ISPS book series, and members have also written a chapter about New Zealand for the forthcoming ISPS book "Past, present and future of psychotherapeutic approaches to schizophrenic psychoses."

Our objectives in New Zealand are the same as the ISPS as a whole. The flavour of our conferences was eloquently captured by Dr Nicholas Marlowe

(Sydney, Australia) when he described our 2004 conference (ISPS Newsletter - Spring 2005):

“The cultural and professional diversity of the speakers ensured a multi-layered perspective on the complex and multi-dimensional problem of psychosis. ... The emphasis was upon understanding symptoms and difficulties within the context of the client’s lived experience. ... The courage and openness with which some of the participants discussed their own personal experience of psychosis and recovery, focused the conference on the necessity of a person-centred paradigm.”

We look forward to getting as many Kiwis as possible to Madrid 2006, and to future ISPS symposia. We are determined to play our part in ensuring that the ISPS goes from strength to strength in the coming years.

Do plan a trip to the land of Gandalf and Frodo soon.

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20 D Eastern Asia: The Singapore Chapter

Lyn Chua

Psychological treatment for mental illnesses has not really been established and its effectiveness not readily acknowledged in Asia. Hence, societies advocating such treatment for mental illnesses have not attracted much support. This is mainly due to the fact that the treatment of psychiatric disorders in Asia has been, and still largely is, very biological in approach. It is only in recent years that psychological interventions and activities like those of the ISPS have caught the attention of mental health professionals in Asia. This has given those in Singapore who believe in the necessity and effectiveness of psychological treatment to initiate the formation of a local Singapore Chapter of the ISPS at the end of the year 2003.

Resistance in seeking psychiatric treatment for psychiatric illness has been a long-standing problem in Eastern Asia. Many East and South-East Asians have retained their faith in “native treatment.” It is very common for people afflicted with mental illnesses or psychological distress to prefer being treated by traditional healers, temple mediums, priests and witch doctors. This is mainly due to their religious beliefs, cultural influences, folk traditions and their superstitions that illness, especially mental illness, is the result of physiological factors (for example, imbalance of the yin and yang) or of supernatural forces (like spirit possession). The process of psychoeducation is an uphill task because of such deeply-rooted beliefs. Moreover, the stigma attached to mental illness is still very strong, and the suggestion of psychiatric treatment in East and South-East Asia is not readily accepted. Psychiatric patients and their relatives are, however, gradually beginning to accept that they have an illness and that, like all other illnesses, they believe they might benefit from taking medication. Hence, the approach in the treatment is still largely medical in nature in these Asian regions, and patients with schizophrenia and other psychotic illnesses are being treated, until recently, almost solely with antipsychotic medication.

Singapore is an island state in South-East Asia with a multi-ethnic population which currently stands at 3.5 million. There are three main ethnic

groups, the largest being the Chinese (77%), followed by the Malays (14%) and the Indians (9%). The various cultural values and beliefs of this multi-racial and multi-religious Asian society play an important role in influencing their attitudes toward the treatment of mental illnesses, especially the psychoses.

The first psychiatric hospital in Singapore was built by the British colonists in 1841; it was then regarded as an asylum for the insane, the approach mainly custodial and medication was given primarily to sedate “troublesome” patients. With the advent of medical education in Singapore, care of the mentally ill gradually improved over the years. Psychiatry in Singapore came of age in the 1980s. It is primarily biological in orientation, with psychopharmacology as the mainstay of psychiatric treatment; psychotherapy has not been emphasized. Although there was a semblance of a multidisciplinary team approach as occupational therapy was present in 1955 and some form of psychological services were introduced in 1956, these were mainly in the areas of rehabilitation and psychometric testing; counseling and psychotherapy were provided only on a “limited scale,” for about only 6% of the patient population as reported by Dr BY Ng in his recent book on the history of mental health services in Singapore. This has remained very much the same, with some small changes until more recently. In April 1993, after several re-buildings and relocations, the new psychiatric hospital and Institute of Mental Health finally settled in its present location as an impressive, modern cluster of low-rise blocks with a bed capacity of 2,943 and state-of-the-art technology.

The usefulness of psychological treatment in schizophrenia and psychotic illnesses came into significance only in recent years in Singapore. Mental health care professionals began to realize the need for a holistic approach, and that medication alone is insufficient in enabling the individual to return to optimal functioning. Supportive and behaviour therapy was previously provided on an ad hoc basis by the staff caring for these patients. However, with the development of the Early Psychosis Intervention Programme (EPIP) in 2001, patients with schizophrenia and other psychoses referred to the Programme were routinely provided with psychological treatment by members its multidisciplinary team. The strategies of EPIP, besides educating the general public about schizophrenia and networking with primary healthcare providers, included the provision of a holistic treatment for all patients. Family and group therapy, individual psychotherapy, psycho-education, social, educational and vocational guidance, and case

management augmented the pharmacotherapy. A culturally-oriented psychotherapy “package” named PASTE (**P**ersonal **A**nd **S**trategic Coping **T**herapy for **E**arly Psychosis) has been developed specifically as a psychotherapeutic intervention for the multi-ethnic patients in Singapore. It takes into account individual patients’ personal, religious and cultural beliefs about the causes of their psychotic symptoms; this contributes to the development of a stronger therapeutic alliance. The psycho-education provided has also been given a culturally-relevant slant.

The upsurge of interest in the psychological treatment of schizophrenia provided the opportunity and platform from which activities of ISPS could be publicized and promoted in Singapore. Interest in the objectives of ISPS grew as a result of the involvement of these mental health professionals in psychological treatment for the mentally ill, and their belief that it is essential and effective.

This interest resulted in the birth of the Singapore Chapter of the ISPS in December 2003. A gathering of 32, comprising psychiatrists, psychologists, social workers, occupational therapists, nurses and case managers voted in a protem committee of nine, which later met to discuss administrative matters like registration with the Singapore Register of Societies, opening a bank account, membership fees, and setting the programme of activities for the following year. Since we started with no funding and minimal membership fees, our activities were rather limited; we were unable to organize any conferences nor invite speakers from overseas. Nevertheless, we managed to take whatever opportunities that came our way. We were very fortunate to have had Professor Max Birchwood from Birmingham, UK, conduct a short workshop on “CBT for patients with First Episode Psychosis” during one of his visits to Singapore in January 2004. Professor Anthony Bateman from St Ann’s Hospital in North London who was in Singapore to conduct a course for the hospital in March 2004, also obliged our Singapore Chapter with a lecture on “Psychodynamic Psychotherapy in the Treatment of Schizophrenia.” These sessions generated a great deal of enthusiasm, discussion and ideas amongst ISPS Singapore members.

Unfortunately shortly after these events, the local Chapter encountered several obstacles and unforeseen circumstances which have hindered further development and progress of its activities. However, there are encouraging signs that the Chapter may regain momentum despite these difficulties as more interest is generated and more new members from

various others sectors of the mental health services are recruited. We are optimistic that we will survive these adversities.

Similar to Singapore, the prevalence of a biological approach to the treatment of schizophrenia is still very predominant in other East Asian countries. Although there has been some indication of interest from other countries in this region, including China, Japan and Malaysia, to form local ISPS groups, they seem to have encountered difficulties in gathering together a group of people to initiate the formation of such groups in their respective countries. It appears that the nature of their work, their main treatment approach and the geography of the country are the main causes of the difficulties. Colleagues in Hong Kong, however, have started holding gatherings which hopefully will evolve into the formation of a local ISPS group.

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Breaking the Covenant

- 21 A.** International schizophrenia research and the concept of patient-centredness 1988 – 2004

- 21 B.** Commentary on “Breaking the Covenant: International Schizophrenia Research and the Concept of Patient-Centredness 1988-2004” by Timothy Calton, Anna Cheetham, Karen D’Silva and Christine Glazebrook.

21 A. International schizophrenia research and the concept of patient-centredness 1988 – 2004

Timothy Calton, Anna Cheetham, Karen D'Silva & Christine Glazebrook

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"There is something seriously missing in a field of mental illness that does not attend closely and broadly to subjective experience and the self" Strauss 1989 p.177¹.

The unconscious covenant

What do or should we value in our attempts to understand human experiences? This universal philosophical dilemma has occupied human beings since antiquity, and has provoked acrimonious debate within medicine in general, and psychiatry in particular. Empirical studies using published research as data have shown that psychiatry, in cleaving to the 'medical model' approach to mental disorder, has traditionally valued objective, fact-based and predominantly biological explanations and interventions for mental disorders throughout the twentieth century⁽²⁻⁴⁾, despite challenges from psychoanalytic theory and the anti-psychiatry movement⁽⁵⁾. It could be argued that this preoccupation with the biological achieved its apogee with the 'Decade of the Brain' initiative of 1990⁽⁶⁾, which mandated a reductionist approach to understanding the brain, and stridently pronounced the validity of a biological perspective for schizophrenia⁽⁷⁾, the paradigmatic mental disorder. Yet, despite the immense amounts of time, energy and resources poured into this positivist endeavour, no truly reliable, specific and objective criteria for differentiating people experiencing mental disorders such as schizophrenia from, so-called, normal people have been identified⁽⁸⁾. Indeed by dint of this it could be argued that psychiatry maintains an often unconscious covenant with subjectivity⁽¹⁾.

The patient-centred ethos

In contrast to the biological approach adopted by mainstream psychiatry, the 'patient-centred ethos', which coalesced as a substantive model for the practice of medicine at the University of Western Ontario in Canada in the late 1980s^[9], explicitly seeks to understand patients' values as lived emotional experiences, taking into account their understanding of their illness and their expectations regarding treatment^[10]. The core feature of the concept of patient-centredness is the need to effect a balance between facts and values, between objective theories of disease and the subjective experience of illness^[11]. Within medicine the patient-centred ethos has been shown to increase patient satisfaction^[12, 13] and adherence^[14], as well as improve self-reported health^[15] and physiologic status^[16]. Within psychiatry, the patient-centred ethos has influenced assessment^[17], the diagnosis and treatment of schizophrenia^[18-20], patients' and carers' attitudes towards services^[21], and the design and provision of services^[22, 23]. Perhaps most significantly, the patient-centred ethos has been enshrined in governmental policies on mental healthcare provision across the world^[24-28]. Hence it could be argued that since the late 1980s theory and research in medicine/psychiatry should have been informed by both the biological approach and the patient-centred ethos. This was certainly the position adopted by our group in attempting to determine whether psychiatry's covenant with subjectivity was honoured within the realm of international schizophrenia research between 1988 and 2004.

The populations studied

Our group evaluated every conference abstract published by the International Society for the Psychological Treatment of Schizophrenia and Other Psychoses (ISPS) between 1988 and 2003. In addition we scrutinised all the conference abstracts published by both the International Congress on Schizophrenia Research (ICSR) and the Biennial Winter Workshop on Schizophrenia (BWWS) between 1988 and 2004. The rationale for selecting conference abstracts was simple; by circumventing the publication bias intrinsic to journal articles^[29], they facilitated a much clearer idea of what the researchers and clinicians who attended these conferences actually *did* and, therefore, valued^[30]. In addition, the vast majority of abstracts submitted to these conferences were accepted for publication^[31, 32], hence there was virtually no attenuation of the research once it had been submitted. The

conferences selected for analysis were, broadly speaking, representative of the global schizophrenia research community: their output was certainly much more representative of the international schizophrenia research output than published work over the same period. The time period was not chosen arbitrarily, rather it represented the point when a distinct dialectic emerged between the biological approach (as exemplified by the 'Decade of the Brain' initiative) and a robust empirical model of patient-centredness. We excluded all abstracts not written in English and removed all duplicates using pre-defined criteria.

Defining the subjective

Our group formulated, by a process of argument and debate, the following operational definition of 'subjective experience' research:

'Subjective experience' research is that in which the main aim of the research is to address the patient's subjective experiences, and their relevance and meaning to the patient, with the latter being evidenced by the research:

- Addressing the patients' individual feelings as 'lived emotional experiences'

OR

- Considering patients' ideas and expectations regarding their illness and treatment.

OR

- Considering patients' opinions in determining the aims and outcomes of the research.

Clearly the emphasis on subjective experience was a logically necessary component, but it was felt that having this as the sole criterion would be too overinclusive and, hence, not discriminate between research that simply mentioned, *en passant*, patients' subjective experiences, and those pieces of research that went beyond this, into the 'lifeworld' of the patient. To go beyond the surface and assess the degree to which the 'lifeworld' was

addressed the phrase “...and their relevance and meaning to the patient” was included. This directly incorporates Mishler’s notion of the subjective meaning of illness events^[33] and was felt, by orienting the definition onto the lived experience of the patient, not the interests of the researcher, to facilitate the discrimination posited above. The term “*main aim*” was incorporated to ensure that only those pieces of research, which maintained, as their primary focus, the subjective experiences of the patient, would be captured by the definition. The subordinate criteria were derived from the Measure of Patient-Centered Communication (MPCC)^[9], a psychometrically robust semi-structured measure of patient-centredness developed to facilitate the assessment of patient-centredness in clinical practice. A broad definition of ‘patient’ was used, based on an understanding of patients as individuals existing within a variety of systems, including the family.

This definition was then applied to all of the selected abstracts, with each abstract being rated as ‘subjective experience research’ or ‘non-subjective experience research’ by the main rater (TC). Additional data were collected for all three conferences on country of author origin and category of research (biological, psychosocial, epidemiology, diagnosis and phenomenology and miscellaneous). For the ISPS conferences data were also gathered on subtype of research (case report, service description, theory paper, outcome or trial paper and miscellaneous) and therapeutic orientation (psychodynamic, cognitive-behavioural, systemic/family or other). Independently assigned data categories were used wherever possible in order to minimise rating biases. For all operationally defined criteria good to excellent inter- and intra-rater reliability was obtained prior to data collection.

Results

Population descriptions

The six international ISPS conferences held between 1988 and 2003 produced 1,154 published abstracts. 153 (13%) of the abstracts from the 1988 conference were in Italian and were excluded, as were 9 (0.8%) duplications. This left 992 abstracts for analysis. The mean number of abstracts presented per year was 165 (s.d. 90, range 61-280). There were a total of 9577 abstracts presented at both the BWWS and ICSR between 1988 and 2004. Of these 293 (3.1%) were duplicates and were excluded. This left 9284 abstracts for analysis with the mean number of abstracts presented per year being 546 (s.d. 307, range 143-1069). Due to the fact that ICSR and BWWS have identical stated subject matter, aims and abstract acceptance criteria, it was felt that combining them into one entity, for the purpose of analysis, was justified, though, for the converse reason, their data were not combined with those from the ISPS conferences.

Figures 1 and 2 show that the total number of abstracts presented at both the ISPS and ICSR/BWWS increased over time. This interaction attained statistical significance in both cases:

Fig 1. Number of abstracts presented at ISPS by year

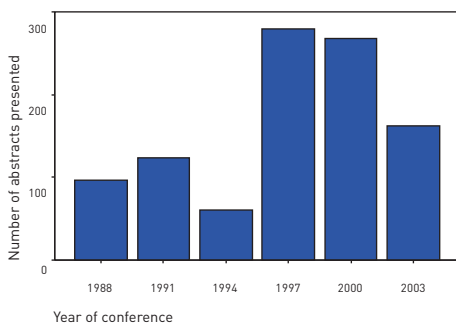
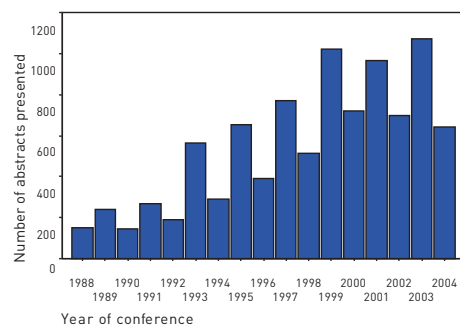


Fig 2. Number of abstracts presented at BWWS and ICSR by year



In relative terms the ISPS conferences produced many more psychosocial abstracts than ICSR/BWWS, with the opposite being true for biologically oriented abstracts, as is shown in **Table 1**. The proportions of abstracts in the remaining categories were similar.

Table 1. Numbers of abstracts presented in each category for both the ISPS and ICSR/BWWS conferences.

	Number of abstracts presented at ISPS (%)	Number of abstracts presented at ICSR/BWWS (%)
Psychosocial	775 (78.1)	449 (4.8)
Biological	36 (3.6)	6960 (75.0)
Diagnosis and phenomenology	63 (6.4)	840 (9.0)
Epidemiology	53 (5.3)	768 (8.3)
Miscellaneous	65 (6.6)	267 (2.9)
Total	992 (100.0)	9284 (100.0)

Abstracts were presented by authors from 45 countries in the case of the ISPS, and from 50 in the case of ICSR/BWWS. In both instances, although abstracts emanated from all six inhabited continents of the world, there was a pronounced Western bias, with, in the case of ISPS, 857 (86.4%), and for ICSR/BWWS, 8574 (92.3%) abstracts emanating from European and North American countries, as is shown in **table 2**:

Table 2. Numbers of abstracts produced by authors from each inhabited continent.

	Number of abstracts presented at ISPS (%)	Number of abstracts presented at ICSR/BWWS (%)
Europe	670 (67.5)	4191 (45.1)
North America	187 (18.9)	4383 (47.2)
South America	9 (0.9)	69 (0.7)
Asia	42 (4.2)	192 (2.1)
Oceania	82 (8.3)	431 (4.6)
Africa	2 (0.2)	18 (0.2)
Total	992 (100.0)	9284 (100.0)

Subjective experience research

333 (33.6%) of the ISPS abstracts primarily addressed subjective experiences, whilst only 183 (2.0%) of those from ICSR/BWWS did likewise. The mean number of subjective experience abstracts presented per year at ISPS was 55 (s.d.32), whilst for ICSR/BWWS this was 11 (s.d. 9). However, the proportion of subjective experience abstracts presented at ISPS conferences actually *halved* over the study period, whilst at ICSR/BWWS it *doubled*, as is shown in **tables 3 and 4**.

Table 3. Numbers of subjective experience abstracts presented at ISPS conferences displayed as frequencies and proportions of total overall number of abstracts by year.

Year of conference	Number of subjective experience abstracts presented per year (total no. of abstracts presented in that year)	Subjective experience abstracts expressed as percentage of total number of abstracts presented per year
1988	45 (97)	46.4
1991	58 (124)	46.8
1994	16 (61)	26.2
1997	107 (280)	38.2
2000	74 (268)	27.6
2003	33 (162)	20.4
Total	333	(992)

Table 4. Numbers of subjective experience abstracts presented at the BWWS and ICSR displayed as frequencies and proportions of total overall number of abstracts by year.

Year of conference	Number of subjective experience abstracts presented per year (total no. of abstracts presented in that year)	Subjective experience abstracts expressed as percentage of total number of abstracts presented per year
1988	2 (148)	1.4
1989	2 (238)	0.8
1990	4 (143)	2.8
1991	4 (270)	1.5
1992	0 (192)	0.0
1993	8 (563)	1.4
1994	4 (289)	1.4
1995	5 (652)	0.8
1996	4 (392)	1.0
1997	14 (768)	1.8
1998	13 (512)	2.5
1999	23 (1021)	2.3
2000	18 (721)	2.5
2001	27 (966)	2.8
2002	20 (697)	2.9
2003	21 (1069)	2.0
2004	14 (643)	2.2
Total	183 (9284)	

Across all three conferences psychosocial research was much more likely than any other category to be associated with subjective experience research, whilst the opposite was true for biologically oriented research. **Table 5** depicts the relationship between research category and subjective experience research, expressed in terms of odds ratios with 95% confidence intervals, for both ISPS and ICSR/BWWS.

Table 5. Study categories associated with subjective experience research; presented as odds ratios with 95% confidence intervals

	ISPS	ICSR/BWWS (%)
Psychosocial	4.18 (2.76-6.35)	14.63 (10.68-20.04)
Biological	0.11 (0.03-0.47)	0.13 (0.10-0.19)
Diagnosis and phenomenology	0.72 (0.40-1.27)*	2.09 (1.41-3.10)
Epidemiology	0.92 (0.90-0.94)	0.24 (0.09-0.66)
Miscellaneous	0.34 (0.17-0.68)	4.94 (3.11-7.85)

*Not significant at <0.05 level as 95%CI crosses 1

In the case of the ISPS abstracts only three countries displayed an increased likelihood of producing subjective experience research (Belgium (OR 4.05, 95%CI 1.21-13.55), Sweden (OR 1.62, 95%CI 1.03-2.57), USA (OR 1.57, 95%CI 1.12-2.21)) and with one, Australia (OR 0.48, 95%CI 0.26-0.87) being statistically significantly less likely to do same. For ICSR/BWWS, six countries (Belgium, the Netherlands, Norway, Austria, Canada and Israel) were associated with an increased rate of subjective experience research compared to the remaining countries, whilst both the USA and UK revealed a decreased rate. The results for the association of research category and country of origin were confirmed by multivariate statistical analysis, using logistic regression to control for potential confounding variables.

The ISPS in detail

The ISPS abstracts were stratified according to subtype of study and type of psychotherapeutic approach. In the case of the former categories imposed included 'case report' (the research sought to describe the unique lived

experiences of an individual person or group of persons), 'service description' (the research simply outlined the activities of an individual therapist, organisation or institution without reference to empirical data), 'theory paper' (the research adumbrated an aspect of psychotherapeutic theory or speculation without reference to empirical data), 'empirical' (the abstract presented findings from empirical research including outcome studies, efficacy trials etc) and 'miscellaneous' (the research could not be subsumed into any other subtype category). For psychotherapeutic approach, the categories were self-explanatory and included 'psychodynamic', 'cognitive-behavioural', 'systemic' and 'other' (akin to the miscellaneous category outlined above).

The results showed that the proportion of case report abstracts decreased by an order of magnitude, from 24.7% in 1988 to 2.5% in 2003, whilst the proportion of service description abstracts increased rapidly over the study period, in contrast to the proportion of theory paper abstracts, which evinced a steady decline. Despite a fall in the mid 1990s the proportion of empirical research abstracts had, by the end of the study period, come to dominate ISPS research activity. These results are depicted below in **table 6**.

Table 6. Numbers of research subtype abstracts presented at ISPS conferences displayed as frequencies and proportions of total overall number of abstracts by year

	Case report	Service description	Theory paper	Empirical	Miscellaneous	Total
1988	24 (24.7)	5 (5.2)	37 (38.1)	29 (29.9)	2 (2.1)	97
1991	33 (26.6)	20 (16.1)	37 (29.8)	28 (22.6)	6 (4.8)	124
1994	14 (23.0)	9 (14.8)	21 (34.4)	7 (11.5)	10 (16.4)	61
1997	36 (12.9)	86 (30.7)	87 (31.1)	55 (19.6)	16 (5.7)	280
2000	26 (9.7)	58 (21.6)	65 (24.3)	114 (42.5)	5 (1.9)	268
2003	4 (2.5)	48 (29.6)	31 (19.1)	76 (46.9)	3 (1.9)	162

In terms of psychotherapeutic approach, the percentage of psychodynamically oriented research abstracts presented declined steadily from 71.1% in 1988 to only 16.7% in 2003. In contrast, the percentage of cognitive-behaviourally oriented abstracts increased from 0 in 1988 to 19.8% in 2003. These results are shown in **table 7**.

Table 7. Psychotherapeutic orientation of abstracts presented at ISPS conferences displayed as frequencies and proportions of total overall number of abstracts by year

	Psychodynamic	Cognitive-behavioural	Systemic	Other	Total
1988	69 (71.1)	0 (0.0)	10 (10.3)	18 (18.6)	97
1991	83 (66.9)	4 (3.2)	11 (8.9)	26 (21.0)	124
1994	35 (57.4)	1 (1.6)	5 (8.2)	20 (32.8)	61
1997	166 (59.3)	14 (5.0)	22 (7.9)	78 (27.9)	280
2000	89 (33.2)	10 (3.7)	9 (3.4)	160 (59.7)	268
2003	27 (16.7)	32 (19.8)	6 (3.7)	97 (59.9)	162

When the relationship between both research subtype and psychotherapeutic approach, and subjective experience research was examined, only case reports (OR 35.86, 95%CI 18.99-67.72) and psychodynamically oriented research (OR 2.44, 95%CI 1.86-3.20) displayed a statistically significant increased rate, with these being confirmed by logistic regression.

Discussion

International schizophrenia research and the concept of patient-centredness

The goal of this study was to investigate the extent to which recent research presented at the most prominent international forums dedicated to schizophrenia research could be considered to be patient-centred. The model of patient-centredness employed suggests that to be patient-centred is to give equal weight to both the subjective experience of illness and

objective theories of disease. We interpreted this to mean that the subjective experiences of patients/research participants be *equally* represented as valid study outcomes and, hence, that *half* of all research projects undertaken in schizophrenia research be explicitly oriented to the subjective experiences of patients/participants. The fact that only 183 (2%) of the abstracts presented at ICSR/BWWS (the two most prominent forums in terms of numbers of abstracts presented) addressed subjective experiences strongly suggests that this body of schizophrenia research has not been patient-centred. Although fully one-third of the abstracts presented at international ISPS conferences between 1988 and 2003 explicitly addressed subjective experiences, the requisite balance was not achieved meaning that, though this body of researchers and clinicians have been much more interested in their patients' subjective experiences, their corpus of work cannot, within the constraints of this model, be described as patient-centred.

The model of patient-centredness deployed within the present study is, perhaps, its most contentious aspect. That is, the balanced model of patient-centredness outlined above may seem rather arbitrary in its placing of equal emphasis on the 'subjective' and 'objective' (or 'value-laden' and 'fact-laden') aspects of mental disorder. A detailed exposition of the argument for this balance is beyond the scope of this paper, though it is well documented in the literature^(10, 11, 34, 35). Despite this, it is worth considering the possibility that the inequities experienced by psychiatric patients (schizophrenia sufferers amongst them) in adverse socio-political contexts such as the former Soviet Union⁽³⁶⁾ and Nazi Germany⁽³⁷⁾, may not have been helped by the lack of weight afforded their subjective experiences/values. These lessons from history suggest that it should be a necessary task of modern psychiatry, and schizophrenia research within this, to balance the desire for objective facts with a humane reflection on subjective experience/values.

Occidental and biological hegemony

Before considering the results from the analysis of the ISPS abstracts in more detail, it is worth reflecting on some of the ramifications of the results from all three conferences: The international schizophrenia research effort, as represented here by conference abstracts from a quorum of forums dedicated to research into this disorder, was (in numerical terms), dominated by both the countries of the West and the biological paradigm between 1988 and 2004. Said dominance may have acted both directly, through the overt promulgation of Western approaches to the understanding

of schizophrenia and initiatives like the 'Decade of the Brain' proclamation, but also indirectly, via the high costs of attending said conferences, costs which may have precluded researchers from less wealthy countries travelling to present their ideas on an international stage. Although schizophrenia can be reliably diagnosed across different countries and cultures, its course and outcome varies considerably between developed and developing countries^[38]. Given that the Western, biologically-oriented approach to the understanding of mental disorder is only one epistemological perspective, it is troubling that researchers from developing countries are not better represented at these forums. Indeed the possibility does exist that the Occidental-biological hegemony afflicting schizophrenia research may be inhibiting a deeper appreciation of the role of cultural differences in at least the course and outcome of schizophrenia^[39].

Breaking the covenant

At this juncture the point should, perhaps, be once again made that ISPS researchers have quite clearly been much more interested in the subjective experiences of those they seek to understand and help, than their counterparts at ICSR/BWWS. That said the proportion of ISPS abstracts addressing subjective experiences decreased substantially between 1988 and 2003. It is ironic, and not a little worrying that, during a period when a substantial number of schizophrenia researchers were not overtly concerned with making subjective experiences the focus of their work, an organisation with a rich tradition of engaging with subjectivity also appeared to back away from this approach. The covenant with subjectivity, struck by all those clinicians and researchers within the mental health arena, on either a conscious or unconscious basis, has been broken in the field of schizophrenia research.

The reasons for this disavowal of subjectivity are undoubtedly complex, and a detailed discussion of the factors contributing to this state of affairs is outside the scope of this paper. That said sufficient data does exist for a speculative, though necessarily superficial, consideration of the factors which may have influenced the creative and intellectual zeitgeist of the ISPS over the last two decades.

The two variables which showed the greatest association with subjective experience research within the present study's analysis of the ISPS abstracts were psychodynamically orientated research and case reports, yet, in both absolute and relative terms, these declined dramatically over

the period of study. Said evanescence occurred in concert with the waxing of service description abstracts, empirical research and cognitive-behaviourally oriented abstracts. Ostensibly these latter groupings share little common ground, yet they could all be said to emphasise description and objectivity over the empathic communion and celebration of subjectivity which certainly adumbrate case reports and which, to a lesser extent, inform psychodynamic practice and theory. The results from ICSR/BWWS show that, at these forums, biologically oriented research, the mode of research that cleaves most readily to the medical model, with its emphasis on objectivity, has been valued above all other approaches. The common factor here would appear to be an overarching epistemology privileging distance, objectification and the existence of an external world beyond human consciousness; in short the positivist value system. It appears, therefore, that in the battle of the ideologies outlined at the beginning of this paper, the reductionist and materialist philosophy of the 'Decade of the Brain' initiative has succeeded in storming what might have been considered to be the last bastion of subjectivity in the realm of schizophrenia research; the ISPS.

Coda

Although the schizophrenia construct remains in many ways an enigma, the positivist/reductionist project, as exemplified by the 'Decade of the Brain' initiative, has produced empirical phenomena sufficiently robust to generate and inform the development of several coherent theories concerning the so-called 'core' neurobiological problem in schizophrenia. The 'brain function laterality' phenomenon and the 'disconnection' hypothesis are two of the most popular and widely known examples: The former, using data derived from functional neuroimaging experiments, suggests that schizophrenia is associated with abnormalities in left hemispheric function, with the general picture being one of functional overactivity^[40]. Indeed the 'reality distortion' symptom cluster, identified via factor analysis of the symptoms reported by people diagnosed with chronic schizophrenia^[41], is specifically associated with overactivity in the left parahippocampal and hippocampal areas^[42]. The disconnection hypothesis is based on the idea that the brain adheres to the two fundamental principles of functional specialisation and functional integration, where the integration within and between specialised areas is dependent on effective connectivity^[43]. Broadly speaking the hypothesis suggests that the 'core' problem of schizophrenia is abnormal connectivity leading to a disintegration of neuronal dynamics in areas such as perception and response selection^[44].

...So what?

Well, the world can be divided up into right and left hemispheres along the convention of the Greenwich meridian. Assuming that each abstract (from all three conferences, $n=10276$) is a marker of functional activity within the schizophrenia research community, it is possible to compare activity between each hemisphere. Between 1988 and 2004 the left hemisphere produced 6889 (67%) and the right 3387 (33%) of the total: In functional terms there has been left hemisphere overactivation. Equally, if one assumes that each of the presenting authors at the ICSR/BWWS and ISPS conferences held between 1988 and 2004 had the opportunity to attend all of the other conferences then, by cross-referencing author lists from the collections of abstracts, it is possible to obtain an estimate of the effective connectivity between these two specialised components of the international schizophrenia research community. In this instance fewer than 20% of the different authors attending ICSR/BWWS had presented their work at the ISPS conferences, and vice versa. In other words the schizophrenia research community has been subject to markedly impaired functional connectivity (or 'splitting' in psychodynamic terms) at the level of the communication of ideas.

Taken *in toto* these findings suggest that, using the same epistemology adopted by the majority of schizophrenia researchers to define those people with the condition as disordered, the self-same schizophrenia research community can also be defined as disordered. The question then becomes what reality has been distorted and what dynamics have disintegrated, by dint of this disorder, at the meta-psychiatric level? It may perhaps be the case that the supposedly objective and material findings of disorder in schizophrenia are, in part, actually reflections or projections of the observing body, in this case the international schizophrenia research community. In short this community may, to a certain extent, be seeing itself reflected in those it seeks to study. If this is the case then the third person, objective perspective of schizophrenia must lose the privilege it has been afforded by the scientific epistemology and greater credence must, in turn, be granted to first and second (intersubjective) perspectives in the study of the schizophrenia construct. Despite the problems currently afflicting the ISPS (see above) it is our opinion that this organisation, with its avowed (though as yet not fully realised) orientation towards both subjectivity and intersubjectivity, offers the best hope of regaining the covenant, and showing the world of schizophrenia research what *should* be valued in our attempts to understand this defiantly abstruse part of human experience.

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21 B. Commentary on “Breaking the Covenant: International Schizophrenia Research and the Concept of Patient-Centredness 1988-2004” by Timothy Calton, Anna Cheetham, Karen D’Silva and Christine Glazebrook.

Brian Koehler

One of the principles of therapeutic community is for the hospital, institution and/or community to examine and treat itself. I believe that Dr. Timothy Calton and his colleagues paper “Breaking the covenant: International schizophrenia research and the concept of patient-centredness 1988-2004” does just that for our ISPS organization. I thought of this principle as I read with great interest the excellent synopsis of Dr. Calton and his group in the UK on the degree to which presentations at ISPS and the International Congress on Schizophrenia Research (ICSR) and the Biennial Winter Workshop on Schizophrenia (BWWS) conform to what is termed a “patient-centred model,” i.e., a model which focuses also on the subjective experiences of patients. Calton and colleagues note that a core feature of the patient-centred model is to give equal weight to the objective theories of disease and the subjective experiences of the patient. Their stated goal was:...”to investigate the extent to which recent research presented at the most prominent international forums dedicated to schizophrenia research could be considered to be patient-centred.” Their application of this model involved a principle that half of all research projects in the study of the schizophrenias should be devoted to the subjective experiences of patients.

Calton and colleagues highlight the growing positivist reductionism in our field. They are holding up a mirror to our organization, showing us what we have become. The papers given at ISPS congresses are increasingly moving

away from an emphasis on subjectivity and phenomenology, as reflected in fewer case studies and theoretical papers. Papers devoted to service delivery and empirical, quantitative research are taking their place. However, ISPS still produces more psychosocially oriented papers than either ICSR or BWWS. My own view is that radical reductionism is crucial, but invalid if left at this level of scientific inquiry. The move away from reductionism in the physical sciences, such as physics, to emergence, is reflected in the work of Robert Laughlin, a professor of physics and Nobel Laureate for his work on the fractional Hall effect. Laughlin noted that the natural world is not only regulated by molecular essentials, but also the powerful principles of organization which flow out of them: This organization can acquire meaning and a life of its own, and begin to transcend the parts from which it is made. At higher levels of complexity, such as is found in human beings and their relational and cultural contexts, cause-and-effect relationships are more difficult to document. The reductionistic positivist ideal that nature will be revealed and understood through division into smaller and smaller component parts or through sophisticated neuroimaging techniques such as fMRI, PET and DTI scans-needs to be supplemented by the study and understanding of how nature organizes itself, i.e., reductionism giving way to emergence.

The principle of giving equal weighting to subjective experience and objective neuroscience research has a long history in psychiatry: I think of George Engel's biopsychosocial model, Leon Eisenberg's caution to steer between a mindless and brainless psychiatry and his quip that the human brain is all biological and all social, John Strauss and Larry Davidson's emphasis on the interaction between person/identity processes and disorder, Yrjö Alanen's pointing out that an important starting point for all integrated psychobiological psychiatry is the insight that interactionality with other people is part of human biology, etc. Kenneth Kendler, psychiatric geneticist, in delineating a philosophical structure for psychiatry, underscored the importance of attending to subjective, first-person experiences. He noted that the goal of psychiatry is the alleviation of the human suffering that arises from dysfunctional alterations in particular domains of subjective experience. Kendler cautioned us not to take advantage of the advances in molecular biology and neuroscience at the expense of abandoning our grounding in the realm of human experience and suffering.

Recently, Chris Harrop and Peter Trower noted that the direction of the causal relationship implicating biology driving symptomatology (upward

causation) has not been satisfactorily demonstrated, and that downward causation may be an equally plausible possibility, i.e., the biological symptoms may actually arise from the symptoms of the disorder. From my review of the neuroscience research, I would say that it is not so much the symptoms which drive the biology, e.g., Edward Hundert pointed out that delusions are often a reflection of the brain's [person's] evolutionary strategy for survival, rather, the biology is the result of experience, in particular profound and chronic stress/fear/anxiety, including exposure to various traumas and prenatal stress. Psychotic symptoms are often very meaningful phenomena when viewed within the context of the individual's life and from within the wider sociocultural surround, as well as from the framework of transgenerational transmission of trauma, which recent research has demonstrated not only has a psychological/symbolic etiology, but a biological one as well (epigenetic modification of gene expression). There are examples of epigenetic, or nongenomic, inheritance, where traits of the parents, particularly defensive responses to threat, are transmitted to offspring in a manner not dependent on information encoded in the nuclear genes. Epigenetics refers to regulation, e.g., by social factors, of gene expressions that are controlled by heritable but potentially reversible changes in DNA methylation and/or chromatin structure. For many years I have been comparing the neuroscience research of schizophrenia with the neuroscience of stress/fear and have found a very significant convergence of findings. It is becoming increasingly clear that the neuroscience findings in schizophrenia research are generally non-specific, possibly due to the important role of epigenetics and neuroplasticity.

At our ISPS conference in London in 1997, Peter Fonagy cautioned our field to not give up our emphasis on intensive psychotherapeutic work with persons with a severe mental illness. Should we abandon this immersion experience with patients within an intersubjective context, what would we have by way of knowledge and skill to teach and pass on to future generations of clinicians? His was a quiet, but powerful voice calling us back to, and not to sever our roots. Perhaps a sequel to the informative and relevant research by Calton and colleagues would be a qualitative study examining the factors influencing this movement away from phenomenology and subjectivity (from the objective standpoint, clinicians may treat their patient's subjective accounts of their experience as indistinguishable from the illness itself, e.g., a reflection of impaired insight, and/or believe that speaking with patients about their delusions and hallucinatory experiences only leads to an exacerbation of the illness itself).

In their summary discussion of their qualitative research study, Calton and colleagues, in an imaginative leap, draw “metapsychiatric” parallels between the psychopathology in schizophrenia, in particular, laterality and disconnectivity, and the splits and disconnectivity in the field of schizophrenia research, especially the split between subjectivity/intersubjectivity research and third person objective research. In response to this metapsychiatric speculation, I would like to conclude with some thoughts of the two co-founders of ISPS, Christian Müller and Gaetano Benedetti. Christian Müller wrote a paper on the resistances we engage in while doing, or to avoid doing long-term psychotherapy with persons with schizophrenia. One could surmise that part of the movement away from subjective to objective accounts at ISPS conferences is a countertransferential retreat from the painful affects stirred up in our dialogical work with patients; work which can potentially reveal to us our own patienthood. Gaetano Benedetti saw the ISPS as a place in which we could autonomously develop our psychotherapeutic understanding and treatment approaches without interfering with other fields of knowledge, such as the progress being made in psychiatric molecular biological or psychopharmacological approaches. Benedetti believed that intensive psychotherapy reveals more deeply the nature of psychosis, in particular, and the human condition, in general. He wished for the ISPS group to return with new and fresh ideas to the significant contributions made by our forerunners, such as Federn, Sullivan and Fromm-Reichmann. My hope is that, as the human cell and person must retain its essential structure as it interacts with its surround, ISPS will remain open to potentially beneficial influences from other domains of scientific inquiry, such as ICSR/BWWS, without abdicating its role as an organization devoted to the psychotherapeutic understanding and treatment of persons struggling with a severe mental illness.

References cited in this commentary are available by request to the author.

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FIFTY YEARS OF HUMANISTIC TREATMENT OF PSYCHOSES

In Honour of the History of the International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses, 1956 - 2006.



PART III:

VIEWS ON THE FUTURE DEVELOPMENT OF THE ISPS



22. My Views for the Future Development of the ISPS

Gaetano Benedetti

I have attended many conferences, seminars and “Weiterbildungen” at psychiatric clinics, psychotherapy and psychoanalysis training centers, mental health centres, therapeutic communities, and I have produced reports on psychotherapy of the psychoses both from a theoretical and a clinical point of view. Many colleagues seemed to be truly enthusiastic especially about the drawings exchanged with the psychotic patients by means of progressive mirror drawing.

Unfortunately this enthusiasm about our method was not followed by an organisational effort to implement it and make it available to patients hospitalized in clinics or treated by mental health centres and services.

This has caused a feeling of uselessness in me: why should I embark in such long trips which take away precious time from my family and my work? However I have not given up and I have not let disappointment and frustration overcome me.

I have attempted to understand the reasons of this failure and I have reached the following conclusions.

1) Psychotherapy with the psychotic patient requires a major effort and it demands the therapist motivation to identify themselves with the patient. The identification, even though a partial one, with the “lunatic” creates considerable resistance particularly in those institutions based on rules and norms. Because of this identification with those who are outside the norm, the therapist is in a position of potential conflict with the institution (as I experienced both in Perugia and in Basel).

2) The therapist-patient and patient-therapist identification, even partial, paves the way for the therapeutic symbiosis which is the alpha and the omega of psychotherapy of the psychoses. The

therapist usually has a number of internal resistances to re-experience symbiotic events. I will never forget a sentence by Searles which has always inspired me: "The reason why psychotherapy of the psychoses lasts for so long is connected to both patient and therapist resistances to enter therapeutic symbiosis."

3) The needs and conflicts of the psychotic patient are of a preverbal nature and they reactivate preverbal conflicts and needs in the therapist counter-transference. In my opinion these conflicts and needs must be dealt with preverbal psychotherapeutic instruments before they can be verbalized. Just as many patients cannot be reached by mere words, similarly the therapist needs preverbal instruments and techniques to elaborate the counter-transference activated by the symbiotic needs of the patient.

The consequence of the above-mentioned points is that:

4) The therapists of a psychotic patient require a reference group within the institution in which they work and with which they can share psychotherapeutic experiences that can be seriously regressive and intense.

5) The reference group within the institution supports the therapist in the process of partial identification with the psychotic patient, reducing their loneliness and their possible "estrangement" feeling, helping them to face the "norm" of the institution.

6) Within the reference group, group experiences and seminars including preverbal communication ways are fundamental in order to bring therapists closer to therapeutic symbiosis and to train them. This can cause, and indeed it always causes, some resistances in a number of therapists, however the most of the group benefits dramatically from a "group symbiosis." In the relationship with the patient, those who have already experienced preverbal symbiosis with their colleagues, are much more confident and open to question themselves in order to come closer to the fragmented experience of the patient.

On the basis of these considerations, I have begun to transmit my psychotherapeutic knowledge and experiences to small groups within

psychiatric institutions. I have been careful to include the theoretical-clinic notions into a training programme based on a non-verbal communication among the participants.

Therefore I have discovered that the more the time and care spent on bringing this group closer to group therapeutic symbiosis experiences, the higher the motivation to implement psychotherapy of the psychoses by means of progressive mirror drawing within the institution.

In this way, in Muensterlingen in Switzerland, and Perugia, Terni and Turin in Italy, it was possible to create groups of colleagues who carry out psychotherapies of the psychoses within the institutions by using progressive mirror drawing in connection with psychotherapy of the psychoses. On 20-21 May 2005 the first international conference on therapeutic progressive mirror drawing took place in Muensterlingen.

On the basis of my modest experience, in order to support the starting enthusiasm and motivation to treat psychotic patients with psychotherapy, it is crucial to provide groups of colleagues with preverbal communication experiences and to organise seminars on the subject bringing thus colleagues closer to group therapeutic symbiosis.

My suggestion to the ISPS is to assist the three-yearly conference, that is an indispensable informative event, with a focus on the needs of psychotherapists of the psychoses, which I have listed in points 1, 2 and 3.

A particular effort should be made for creating, within psychotherapeutic psychiatric institutions, therapist groups trained for facing symbiotic relationships daily and trained for dealing with the resistances caused by symbiosis.

A practical way could be the establishment, during the one-week ISPS conference, of a group of participants interested in exploring preverbal communication ways in order to bring the group closer to symbiosis.

Another way could be an ISPS proposal to the psychiatric and psychotherapeutic institutions about the creation of constant training of groups of colleagues willing to explore preverbal communication ways which make symbiosis familiar.

I insist on this point very much because I think that if the therapist manages to overcome the fear of symbiosis, then the work is half done. Of course the resistance of the patient is still to be overcome, which is impossible sometimes, but anyway the therapist will have made an effort to look for new ways to overcome those resistances.

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23. The Understanding and Treatment of People with Schizophrenia

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Over the years approaches to schizophrenia and other mental disorders have veered wildly from one extreme to the other. This has been especially, but not exclusively, true of American psychiatry. When I was a psychiatric resident in the 1960s a large number of chairmen of major departments of psychiatry in the US were psychoanalysts. Now, a large number are biological psychiatrists. Common assumptions in the 60's that schizophrenia was a result of childhood traumas and environments and thus that the primary treatment was psychological have been replaced by the view that schizophrenia is a brain disease, "like any other illness" and that the treatment is primarily biological. (It is difficult not to believe in the theory that history runs in cycles, here we are again repeating in a new form the beliefs dominant at the end of the 19th century). In between the eras of psychological and biological domination, there have been brief bursts of belief in the importance of social factors (e.g. schizophrenia is found most often in the lower classes "because it is there that people are the most helpless and overwhelmingly dominated by their milieu"). In my experience, each phase of these viewpoint shifts is enveloped in a belief cloud of almost total certainty with a bit of disdain for (and neglect of) other possibilities. Although these wide swerves of viewpoint are generally less pronounced in other parts of the world than in the US, those other regions are not immune either. In this wild ride, the ISPS has been a bit of a gyroscope, less influenced by the swings than most groups, trying often to hold a steadier course.

In this role of the ISPS where a variety of views individually and in various combinations are often considered seriously, it is almost too bad that our group has the title it does, since psychotherapy and even broader psychological treatments, while often a major focus, have rarely been the only ones receiving our attention. The interest in a broad range of

possibilities for the causes and treatments of schizophrenia, gives our group the almost unique possibility of being a major leader in the field and a hope for the future if, as many of us believe, schizophrenia really has a complex biopsychosocial origin and equally complex routes to improvement. Although there are other people or groups who espouse such a belief, there are really very few for whom it is more than a kind of slogan and who take it seriously in their work.

But this broad view is a difficult one to take seriously. It requires attention to complex thinking (e.g., Morin, 1990) and to systems theory which as the sociologist Norman Bell taught is not really a theory at all, but a way of looking at phenomena. It is a way that is difficult indeed. Thinking in terms of multiple processes seems so realistic, so sensible, and makes such good clinical sense. And it is so difficult to deal with scientifically. Nevertheless, many of the members of the ISPS have been world leaders in this difficult and still unfinished task.

But I am a naïve American from Erie Pennsylvania, a small city in what is almost the midwest of the United States, and I was raised with the romantic notion that it is possible for things to be perfect, definitive. For an illness, someone discovers the cause, the cure, and that's all it takes, with great relief for all concerned, patients, families, clinicians, researchers. I actually believe that you don't have to be from Erie Pennsylvania to be that naïve. Some of the power behind the many notions of a single cause for schizophrenia and for its definitive treatment (which to me seem so simplistic) arises from such beliefs. Now I know after all these years that life is not always (maybe never) that simple, but still, identifying definitive causes and treatments is a great model to aim for. And with schizophrenia, our theories, treatments, and findings are very far indeed from that ideal. We have made progress I believe. But we have so far to go.

So what can the ISPS do? What should be our role? For one thing, I think we should be in the center of the field of the world of mental health research, theory and treatment, not on the edge where we often find ourselves. There should be hundreds, maybe thousands of people coming to our meetings, meetings which should be seen as the forefront of progress. We should be recognized as the leading edge of theory, treatment and research. There I go again, being from Erie Pennsylvania. But what holds us back? Why aren't we that way? What's wrong with people that they don't see us that way. Maybe something is wrong with us too?

Unfortunately, I do not have the definitive answer. But I do have two suggestions. The first regards the simultaneous need for theory and data, not so easy as it might seem. The second suggestion, not unrelated, regards point of view, from whose perspective do we define the data that are the core to our future directions and knowledge. Specifically, in this difficult and fascinating field which ought to be a human science, how do we deal with being scientific about humans, how do we deal with subjectivity and objectivity at the same time?

Theory and Data. In the domain of mental health, as in many human endeavors, people tend to be specialists, good or even excellent in one area, and not so good, or even incompetent or uninterested in others. In the mental health field, it is extremely difficult to be skilled at collecting and analyzing data, and also at developing theories that are both valuable and profound. It would be hard not to get into arguments immediately about this point and I have qualms about giving examples. Nevertheless, I will start with one that makes it particularly difficult for many of my friends to discuss these things with me. For many years after getting into psychiatry I couldn't understand why Freud had never been given a Nobel Prize. His theories were so beautifully and profoundly developed, based I thought on solid clinical data. I tended to accept the paranoid interpretation that the Nobel Prize Committee was prejudiced against anything psychological, especially if it had something to do with sex. Then, when I became involved with "descriptive psychiatry" with its rating scales and structured interviews (which would have gotten me ejected from my psychodynamically oriented residency), I began to realize how important measurement was. How crucial were supposedly simple ideas like reliability, the capacity for different people to agree on what to call or rate something. What I had at first believed to be pedantic exercises in assigning a diagnosis, I began to see as the difficult and crucial task of assigning accepted meaning to a noun. I then recalled that during my medical student and residency years, when I sometimes asked a supervisor why a patient had been diagnosed as schizophrenic, I got serious, but now incredible, answers such as "because she's been sick so long", or "because he relates so poorly to people", or even in one instance, "because he's in this hospital" or of a patient in a famous twin study, "because his twin has schizophrenia". A problem in the United States certainly, but as I learned later in participating in international studies with the World Health Organization, certainly not a problem limited to the US. Difficult to build a science or a knowledge base of any kind without better reliability of nouns (or verbs) than is provided by such diverse and

idiosyncratic criteria. If definition and measurement are crucial and complex, so are sampling, statistics, and analysis of results. Good science is really complicated.

But people who are good scientists, comfortable in the complexities of scientific method, seem to have trouble developing profound theory. I long for the days when I could read Freud with total enthusiasm. His theories still seem to me to be a model of human depth and insight. But when I read a book like *The Wolfman* (Gardiner (ed.), 1971) that contains Freud's case analysis with his descriptions of the Wolfman's conflicts and Freud's interpretations, and also contains the autobiography written by the "Wolfman" himself, I am even more impressed by the degree to which in formulating his theories, Freud seems to have left out huge amounts of data, even data involving his own interventions (such as Freud's lending the Wolfman money, helping him find a job, or making suggestions about a woman whom the Wolfman thought about marrying). On the other hand, when I read writings by people who know intimately the complexities of data collection and analysis, I so miss the kind of profound theory of which Freud was capable.

One direction I would like to see the ISPS members take, and to encourage younger members in the field to take as well, is this problem of knitting together really good deep theory with the respect for the complexities of science. What does such a combination involve? For the theory part, I think we need a theory that deals in detail with a person's psychological processes, a person's experience, his or her way of handling information and feelings, as well as processes of biology and social context.

For the science part, an appreciation is necessary for the issues of definition, measurement, sampling, statistics and analysis of results noted above. Case studies are useful as well, although we need a context within which to place them to assess their validity and generalizability. But because we are a human science, a science that attempts to deal with the complexities, bio, psycho, and social, that are essential to being human, I believe we also need to expand the view of science. We need a science that does not throw out data because we don't know how to measure or define them yet or because we have not developed means for dealing adequately with a particular kind of information. This holds most especially for the area of subjectivity. Yes, qualitative research is important, but to make it "scientific" we tend to bend it towards the quantitative thus losing the kind of power so central to human

subjective experience, the kind of power for example also generated by narrative and by the arts. That aspect of experience is a major part of subjectivity. Thus, one of the difficulties in putting together deep theory and data based science is that we need to develop a notion of what an adequate science for humans would really look like. An ideal task for members of this group!

Objectivity and Subjectivity. Which brings us to my second and related suggestion. Much of mental health research these days emphasizes what is understood to be careful science: hypothesis testing, sampling, collection of reliable data, valid statistical analysis, and the drawing of conclusions closely related to those findings. The contemporary theories of mental disorder and approaches to treatment that are most common evolve from this base. All this is crucial. But what is almost always ignored is the huge amount of data that is the most difficult to collect and analyze, subjective data. It is poor science to pay attention only to the data that are relatively easy to collect while ignoring huge amounts of data that are more elusive. The old joke comes to mind about the drunk man who lost his keys in the middle of the block but looked for them at the corner “because the light is better here”. How can we in academic mental health fields neglect so consistently that huge area of human experience that is related to subjectivity? By subjectivity, I do not mean only the “do you hear voices” kind of question on which much of my own earlier research was based. I do not even mean the “are you working” or “are you happy” kind of questions which, trying to be broadminded, we have asked searching for measures of “competence” and “quality of life”. I mean rather the kind of subjectivity that has to do with the depths and complexities of feelings, of intentionality, of meaning, and more inclusively, with the question, “how does this person see himself and the world?”

Now, an adequate pursuit of that problem is going to take some creativity. Many of us think we already know such things about our patients. And here arises an ongoing problem in my career, how to undertake the task of trying to say that our ideas of a phenomenon are incomplete, sometimes even wrong. In contacts with theater people, actors and directors, I am continuously amazed, how many very smart, capable and hard working people spend their entire lives trying to grasp how, really, one person or another sees himself and the world. These theater people help each other and hire coaches throughout their lives to deal more adequately with this ongoing question. Are we so much smarter or more talented than they that we have already more or less solved this problem? One experience I had in

this regard occurred about five years ago when I took an acting class. I did it not to become an actor but because it interested me and because I was always so bad the few times I tried. As I watched the excellent teacher, Doug Taylor, at work with successive pairs of students who had been assigned a role from a famous play, I was incredulous how much it was like watching a kind of controlled experiment. The words from the script were always the same, but at the start of the students' efforts there was nothing real about the performances. They felt lifeless. Little by little, suggesting how they might get in touch with their own experience, gestures they might try, things they might think about, Doug helped the students find the "truth" of their characters. The words were such a limited part of the reality! Do we know much about this huge other than verbal area of the psychological and interpersonal world? Do we get training for it? How recently have you seen it included in a theory or treatment for schizophrenia? In an art exhibition entitled "Moi" at the Musée du Luxembourg in 2004, there were assembled a large number of self portraits by 20th century artists. It was overwhelming, the diversity of ways in which people represented themselves. Some had painted traditional self portraits, pictures of their head and shoulders, others had painted themselves with their families, still others had painted only their painting materials, others had painted several different images of themselves in the same picture, others abstractions, some only words painted on a canvas. Incredible diversity of how people see themselves! To say nothing of how they see their world.

"We do it (or we know it) already". Always a difficult part of a discussion when someone tells you that. I will recount one final experience that might help. A few years ago I was presenting a talk and a workshop for a group in Tromsø in the north of Norway. The group included about 150 people, mostly mental health professionals with a scattering of "consumers" and family members of consumers. My experience with mental health professionals in Norway is that they are unusually eclectic and open minded (and nice). As part of the program and to do something a little different, I had asked an excellent psychiatrist I know there if he would interview me in front of the group. I would be someone with paranoid schizophrenia and he would be doing a follow-up interview with me. A follow-up interview because we had done an initial interview ("intake") a couple years previously with a smaller group elsewhere in Norway. That experience had gone very well. He was a wonderful interviewer and we would stop every few minutes for people in the audience to ask questions or make comments, or we might make some comments ourselves. For this follow-up interview, "my psychiatrist" started

by asking me how things were going. I told him “a little better” saying that the voices were not so loud and that I was working at McDonalds. The job wasn’t great but it was better than nothing. He then asked me about friends and family, and very rapidly, I found myself only answering with one word replies and really not wanting to talk to him any more. It was terrible. I couldn’t get myself out of that frame of mind. There I was, a major guest of the conference, all those people out there, and I didn’t want to talk any more. We struggled on for a few more minutes, and then I said I thought we should stop and see if we could make any sense of what was going on. I really didn’t understand except that this strong feeling of not wanting to talk further had seized me. The other psychiatrist and I both said a few more things and then we opened the discussion to the audience. Several comments and questions were volunteered. Many of the questions asked (in a nice way) why I was being so difficult. I didn’t know myself but then someone at the back of the audience raised his hand and said, “I’m a consumer too, and I’ve had the same experiences with my psychiatrist, and he never understands”. Then another hand went up at the front of the room in the corner. “I’m a consumer, and I’ve had the same experience with my therapist and she doesn’t understand either”. Well, at least there were three of us, I wasn’t all alone. The entire group spent the rest of the time discussing this situation. And it was always the three of us “against” all of them. We could never get them to understand our point of view (nor could we understand theirs). There was never a coming together. Later, I thought perhaps my problem was that when I talked about my work at McDonalds, the psychiatrist just went on to his next topic, my friends and family. But I wanted to talk more about my job. I think I just felt that if he didn’t want to hear about what was important to me, I wasn’t interested in answering what was important to him. Whatever the cause, it was a very unsettling but very powerful experience. Not so easy to understand the point of view, the subjectivity of another person, or even to accept fully its existence.

Brain science passed through a phase of phrenology, the study of bumps on the head, partly because there were only limited ways to do better. But that did not mean that phrenology was sufficient. In the sphere of subjectivity. In our scientific endeavors, we currently collect information on symptoms, observed behavior, perhaps even social data which we professionals label (that question of definition again) as competence. These measures are probably much more valuable to psychiatry than was the study of phrenology to brain processes, but just because they are measurable does not mean that they cover the subjective aspects of our field in an adequate way.

The ISPS is such a wonderful group to explore these two areas, the bringing together of science and deep theory to understand illness and improvement processes from a psychological biological and social base, and the developing of a view of science that involves meaningful inclusion of subjectivity. Pursuing these tasks in a more focused way, we could be an even more meaningful force towards developing our field to become truly a human science.

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24. Towards a deeper integration of psychological and humanistic values in the psychiatry of psychoses

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There is presently a heavy dominance of biological ideologies and practices regarding psychosis treatment. This implies an important increase in the interest in nosology, definitions, and effectivity of treatments. However, we can observe negative consequences of a one-sided interest in pharmacological solutions of the psychotic disorders, neglecting the patient's needs as a person. There is also academic lack of interest in the long-term relational aspects of care and a lack of effort to act as the patient's consultant and not as his or her boss. This lowers efficacy in care of psychosis; it even becomes counterproductive with distressing and overstimulating patient wards, little continuity in out-patient care, distrust of medication, and deficient knowledge of the patient as a person and of the family's capacities and problems.

We faced the opposite situation in many parts of the Western world one generation ago. There was a monopolization of psychoanalytic concepts, and psychodynamic reductionism reduced interest in biological research even leading to a suspicious attitude about it. There was a simplistic view of psychosis considering that it mainly expressed a regression to a relational disturbance during the first year of life. Treatment implied a guided regression to that stage with corrective emotional experiences and a new journey back to mental health. The "psychosis therapist" had mythological and heroic capacities like Orpheus bringing Eurydice back from Hades. This view, which is not difficult to understand as such, made critical discussions seem impertinent. Supportive dynamic psychotherapy was downgraded as second best. (Psychotherapy of psychosis-like chronic dissociative conditions after early sexual abuse lead to more associations of this kind. Such conditions are often misdiagnosed as schizophrenia).

The psychoanalytic golden era suddenly came to an end. It was repeatedly shown in the early eighties that the therapeutic gains were very limited in most cases of psychoanalytic treatments of long term schizophrenia and it could scarcely be regarded as an acceptable method, also considering the expenses in time and money. This does not mean that psychoanalytical theories of pre-oedipal development need to be abandoned. They may provide a deep meaning for the understanding of psychotic thinking. But the causal view on disturbances during these stages being the genesis of a psychosis is not well founded and also counterproductive to good care.

Neuroleptic treatment was regarded as the only effective therapeutic agent in many clinics. In fact it was believed that the risk of postponing the treatment of a schizophrenic patient implied immediate neuroleptic treatment and nothing more. The myth of a “toxic psychosis” included the need for “immediate neuroleptization”, and was widely spread all over the world during the early nineties. Doses were high and the patients’ and relatives’ protests were regarded as expressing their lack of education. However, PET studies from the late nineteen-eighties slowly brought psychiatrists to understand that the doses they were taught to use were five times or more too high, leaving the patients chronically intoxicated with a ruined life quality. Suddenly, the patients’ complaints were listened to. New types of antipsychotic medication were also produced with somewhat less devitalizing side effects. All these agents, however, have other specific side effects, which after a period make them less popular. I believe that the last century’s misuse of neuroleptic medication will be regarded, by a later generation, as one of the deplorable encroachments on the rights of mental patients. As a life-long functional lobotomy, it is comparable with the large scale surgical lobotomies a little earlier.

At present, family treatment and cognitive psychotherapy are both regarded as evidence based treatments in schizophrenia, beside medication. It will be a question of time and research to show that specific dynamic therapies are essential in working with acute psychosis. In spite of this knowledge implementation of professional psychological treatments is meager. One reason for this is the impact of the pharmaceutical industry with its huge economical resources. But there is a visible change at present towards more integrative views on psychosis and schizophrenia. Gradually both researchers and clinicians have begun to realize that a biological or psychosocial view is insufficient. We have to adapt to a dialectical view, trying to expand several theoretical models and to apply them simultaneously.

There will always be an epistemological gap – clinical experience will testify how wisely we adhere to that gap or if we choose to deny it.

The impact of ISPS becomes visible here.

We presently know through extensive research that there are three elements in the treatment of psychotic patients that are not exchangeable and which all must be considered. They are

- *a good milieu* in a comprehensible and low-stress environment
- *reliable and constant therapeutic persons* who may be forming a containing relationship with the patient, and the relatives
- *pharmacological treatments* of sedative and/or antipsychotic types at *lowest effective doses*

The primary idea for me with the ISPS is to form good arguments for professionalizing and increasing the psychological care in all psychiatric clinics, thus humanizing the treatment of psychotic patients. That means that we should show that we cannot treat these patients as if the main problem is to provide his or her malfunctioning D2 receptors with antipsychotic medication immediately, and with sufficient doses. Instead we must demonstrate the meaningfulness of approaching the patients as individuals who primarily need understanding, human encounter and realistic hope. Through intensified bio-psycho-social research and much more listening to and talking with psychotic patients we may better understand their psychological situation and that they are not different from others, even if their needs are sometimes expressed in more complicated and distorted ways.

To conclude: In the decades to come I hope that the ISPS thinking will penetrate even deeper into the psychiatric services. I hope that the struggle between biological and humanistic and between cognitive and dynamic will increasingly belong to history. We shall have to regard our task in a dialectical view. The risk for mistreatment will be diminished when we try to keep the three requirements of psychosis treatment in mind, not monopolizing one of them.

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25. The Future of Psycho-Social Approaches to Schizophrenia: Facing up to the Challenges Ahead

John Read

My Maori colleagues here in New Zealand argue, convincingly, that the trouble with us Europeans is that we move into the future facing forwards. This has some obvious advantages, such as not walking off the end of a pier. They suggest, however, that it is wiser to walk forwards looking backwards, so as to remember where you are coming from, and especially to pay tribute to those who went before. I have recently begun many of my lectures with this anecdote, since it is rather pertinent to my main area of research, the childhood and intergenerational origins of madness. In the context of this book, however, it reminds me to pay homage to those who have battled, long before I joined in, for the rights of people who experience what 'western' societies call psychosis to be listened to, to be understood in the context of their life histories and to have their experiences treated as valid and meaningful by mental health professionals. So let me do that by saying how honoured I felt when Yrjo Alanen invited me to be part of this very special book. To be in the company of so many legends of our field, some no longer with us, is a lovely feeling for me. Thank you Yrjo, and thank you to all who have laid the bedrock, over the past fifty years, for the future that I will try to discuss here.

My own history with the ISPS is short in comparison with most other contributors to this book. Prior to 1999 I had not heard of ISPS throughout 20 years of working (as a clinical psychologist) with, or managing mental health services for, people diagnosed psychotic, and, since 1994 when I entered academia in New Zealand, researching the psychosocial causes of hallucinations and delusions. This may say something about the relatively narrow focus of ISPS historically compared to now, and may be my first clue to what might determine the future. Why did I only hear about the ISPS as a result of being approached because of my research publications? Have we

been guilty, in the past, of not reaching out broadly enough to the thousands of people around the world, including professions beyond psychoanalysis and medicine, as well as service users and their families? How many, like me, would be delighted to find they are not alone in trying to make sense of psychosis and to provide humane alternatives to the dominant 'diagnose and drug' paradigm? How many would have found comfort, support and inspiration from discovering that there is, and has been for decades, an international organisation dedicated to furthering that cause? Or perhaps my ignorance of ISPS had more to do with my having somewhat despaired of professional organisations ever addressing these important issues and my having, therefore, put my energies more into supporting user/survivor led groups?

Certainly when the call came I was very excited. Jan Olav Johannsen wrote to inquire if I might possibly be interested in presenting my research on the relationship between child abuse and subsequent psychosis at the ISPS 2000 Symposium in Stavanger. He didn't exactly have to twist my arm. I arrived on my first ever trip to Scandinavia expecting to find perhaps fifty people, half of whom would see psychological treatments from the traditional 'adjunct to the essential medication' perspective. I found 800. Moreover, I came to realise, from countless conversations with some truly inspiring folk, that most present seemed to believe that psychological understandings and treatments were at least as important, or more important, than trying to artificially alter people's biochemistry. They understood that mental health problems, including psychosis, were largely caused by other human beings - including the social circumstances we collectively inflict on some people, and that therefore the best solutions were probably human rather than chemical or electrical.

Surrounded by all these bright, enthusiastic, dedicated people from all corners of the world, the future of the ISPS as an organisation, and the future of what it has been promoting for 50 years, seemed very secure. But I was suddenly awakened from my dream. A plenary speaker, from the U.S.A., was displaying a huge slide of 'the schizophrenic brain' and promulgating the usual poorly substantiated dogma about genetic predisposition and brain disease. Surely this would be challenged from the floor of the conference. I waited. It seemed, to me, to be a defining moment for the future. Surely someone at this conference, of all conferences, would find the courage to speak about the lack of good science underpinning these stale, old, simplistic and reductionistic myths and how they have

induced unwarranted pessimism, in clients, families and professionals for decades. Surely someone would point out that finding some malfunction in the brain tells us nothing about whether the person concerned has a genetically-based illness because, of course, the brain is effected by the environment. Surely, at this conference, someone would remind the speaker of the irrefutable evidence that social factors, poverty for example, are powerfully predictive of 'schizophrenia'. I waited, determined that for once it would not be me who raised these issues. I needed to know if, despite all those wonderful conversations I had enjoyed, nobody was willing to publicly challenge what, to me, are some of the primary obstacles to achieving the goals of the ISPS.

Sadly, it has become frightening for us to go against the grain on these issues. I have, so many times, seen junior staff or family members try to argue that someone's 'symptoms' (or complaints as Richard Bentall prefers in 'Madness Explained') are understandable reactions to something that has happened to the person. At this point a psychiatrist (or, to the shame of my own profession, sometimes a psychologist) will explain, politely to the family member but often rudely to the staff member, that what we are dealing with here is an illness, a brain disease, a bio-genetically based disorder that has little or nothing to do with life events or circumstances. When 'patients' try to make the same point they are accused of not having 'insight'. What better indicator is there of the dominance of the 'medical model' than the sad fact that the term 'insight', which used to refer to our ability to understand our current difficulties in relation to our life histories, now means our willingness to agree with our doctor about the causes of our problems. Well, actually, I can think of a few competitors for this dubious honour. How about the fact that programmes to 'educate' families that schizophrenia is an illness and that early family environment is therefore entirely irrelevant have been called 'psycho-education' rather than 'bio-training'? Another contender might be 'compliance therapy' - the use of cognitive and other therapy techniques to persuade people to take their drugs.

It can be an even scarier business to go against the grain outside the domain of clinical practice. Most mental health professionals and academics in the field tend to stay well clear of the media. I can see why. The many terms publicly thrown at me by biological psychiatrists when I have disseminated my own research beyond the safer territory of scientific journals include 'dangerous', 'naive', 'family-blaming', the all encompassing diagnosis 'anti-psychiatry' and, my personal favourite, 'unreconstituted Laingian'. I am, of

course, by no means alone in being publicly vilified for publicly citing the research that shows how very limited, and sometimes just plain wrong, simplistic biological explanations of, and treatments for, madness can be. Many before me have paid a much greater price. The question, for the future of the ISPS, how many will have to speak up, together, before we can do so without fear of attempts to bully us back into silence?

So I do understand just how scary it was, in Stavanger, in 2000. I assumed, and hoped, that many others were sitting there wondering whether it was worth challenging the ideologically-driven inaccuracies and assumptions of the speaker and his 'schizophrenic brain'; wondering whether they could get the words out right; fearing that the response would be the usual condescending platitudes implying that the challenger was ignorant or naive. So when I did eventually stand and raise my hand, which I noticed was trembling even more than my knees, it wasn't to find out how the speaker would respond. I knew that. I wanted to know what the other 800 people in the hall thought. If my challenge was met with the usual silence (and the usual, comforting but politically useless, 'well done John's afterwards in private) perhaps the ISPS was not for me after all. Very accustomed as I am to public speaking I was horrified to find that my voice, on this occasion, was shaky, that my sentences were getting muddled up, and that the microphone in my hand was dancing merrily around and getting rather damp. I sat down wishing I hadn't bothered. But then the applause reached my battered ego. It was strong and sustained. I knew, then, that my involvement with ISPS would be equally strong and sustained.

The purpose of this rather egocentric, perhaps narcissistic, approach to assessing the future of the ISPS is to identify what I believe are some of the barriers to furthering the goals of the ISPS over the next 50 years. What has been achieved in the first 50 years has been documented earlier in this book. It is impressive. It is *especially* impressive because of the professional and political climate in which the various successes have been accomplished. The ISPS was formed almost simultaneously with the introduction of the anti-psychotics in the early 1950s. The ensuing decades saw, in the mental health field in general, a significant and sustained lurch towards the nature end of the timeless 'nature-nurture' debate. Psychological treatments gradually became firmly relegated to accessories to drugs, rather than treatments of first choice. Psychologists for instance, who should have been taking life histories and helping people make sense of their disturbing experiences, busied themselves designing ward management programmes (revealingly entitled 'token

economies') to assist the nursing staff maintain some semblance of control in the inevitable chaos of hospital wards. (Will we ever learn that it is not a good idea to round up the 100 or so most distressed and distressing people in the neighbourhood, put them in the same building and then claim they don't improve there because of the debilitating nature of their illness?).

This overemphasis on the bio-genetic, at the expense of the psycho-social, was exemplified by the 1990s being called 'the decade of the brain'. This was all fuelled by many factors. How the ISPS relates to these factors will, I believe, be the major determinant of how the ISPS, and the aims it aspires to, will fare over the next fifty years. The first step is to name these barriers to a more humane, effective and evidence-based approach to psychosis. Doing so is itself a barrier for many. For some, especially academics, identifying economic and political variables goes beyond our 'area of expertise'. It takes us beyond the realms of 'science'. Too many of us still believe that mental health policy and practice is largely determined by value-free research. From this perspective what we should focus on in the coming years is a better research-base for our various psychological treatments. This is, of course, hugely important. One of the most exciting developments in the few years of my involvement with ISPS has been the growing involvement in ISPS of the British cognitive psychologists who have demonstrated that their own approach to treatment works, and that it works with or without medication. While this seems to be a worry to a minority of psychoanalysts who may fear a take over by a less 'in depth' approach than their own, the ISPS is more likely to accomplish its goals the more it can demonstrate, *to other people*, that a range of psychological approaches to treatment do in fact work. It is not enough to 'know' this yourself from your own clinical experience.

Nevertheless I doubt that any amount of well-designed research will, by itself, be sufficient to bring about the changes that so many within ISPS have worked for since 1956. So here is my best attempt to list the factors, beyond good research, that will determine the success of the ISPS beyond Madrid 2006.

Highlighting the social causes of psychosis.

Our historical focus on treatments rather than causes has sometimes limited our involvement in the crucial nature-nurture debate with regard to

psychosis. Some of us may have decided that because it is now accepted that everything is partly caused by genetics and partly by the environment (or more accurately by interactions between the two sets of factors) this is a futile debate. However, the *relative* emphasis we place on the two is hugely important in terms of policy and practice and cannot be ignored. We should therefore support and encourage research-based challenges to the often methodologically weak bio-genetic theories that have dominated for so long.

While further etiological research will obviously be welcome we have to read, and overcome our polite silence about, the existing research about poverty, violence, urban living, isolation, child abuse, discrimination etc

We must not be fooled by the current illusion of a 'bio-psycho-social' paradigm that does include psychological and social factors in the 'stress-vulnerability' equation but only in the relegated role of exacebators or triggers of a predominantly bio-genetic vulnerability. We will need to argue, repeatedly it seems, that abnormal neurotransmitter function or brain structure is not evidence of a brain disease of the kind that is largely unrelated to the social environment. Brain researchers in other fields understand that the brain is inevitably influenced by the environment (especially, but not only, in the earliest years of life). We must help biologically oriented psychiatrists and policy makers grasp this fundamental fact

Working with the consumer/survivor movement

There are good arguments to have a professional only organisation. Apart from anything else, the understandable anger of many 'user' groups is sometimes turned on those organisations most willing to work with them. This can be painful. Nevertheless we risk emulating the systems we are trying to change if we fail to find meaningful mechanism for working together on shared goals. And what about families? Currently the primary organisations for family members adopt, with eager financial support from the pharmaceutical industry, a biological/illness framework. Many family members have told me over the years they are uncomfortable with this approach, or with being told what to think by any organisation. Finding ways to include family members who share our goals will not be difficult. Some ISPS branches are already including service users and family members and this could be formalised at an international level.

Challenging the biasing effects of the pharmaceutical industry

There is no getting around the fact that it is in the interests of drug companies to promulgate bio-genetic causal theories and medical treatments. It is their job to produce profit for their shareholders. They do it very well, with massive resources of the kind we can never match. The ISPS faces a major strategic and ethical challenge here because we have a history, like almost every major organisation in our field, of accepting drug company money. Without them, we have come to believe, we could not hold our conferences or fund our newsletters. I am not convinced this is true. Our annual conference in New Zealand (in its third year in 2005) is attended by 200 people and is self-funding. Admittedly it is a far bigger enterprise to organise an international symposium. On the other side of this argument our 'sponsors' have not yet influenced the content of our conferences (other than by their advertising). Perhaps, one might argue, as long as they are willing to stomach some of us identifying the many adverse effects they have on our field, and some of the tactics they use to maximise their profits, we should continue to accept their money. Personally I look forward to a time – hopefully before fifty years have gone by – when this will no longer be necessary.

All of this leads me towards the central strategic challenge facing ISPS. It is the same challenge faced by any organisation trying to promote an agenda against powerful vested interests. Those interests, for us, go beyond the drug companies of course. They extend to national governments who are only too delighted to be told that psychosis is a bio-genetically based brain disease and that therefore nothing can be done to prevent it by improving the social conditions in which our children grow up, that all we can do is to spend more money on drugs to 'alleviate the symptoms.' The challenge is how to grow the organisation so as to achieve its goals without alienating those who currently disagree with us. For example, how do we persuade more psychiatrists, without antagonising them, that their drugs should not always be the first line of treatment and that their diagnostic labels may be doing more harm than good? I don't know the answer to this. I do know that being silent is not an effective method of persuasion. When I sometimes feel that I have annoyed a potential ally by putting the case too strongly I reassure myself by remembering that you can't win everybody over to what you believe and that you can be so fearful of alienating people that you end up not saying

what you really think. I am also bolstered by the fact that general population survey all over the world find that the public (our clients !) (1) understand that psychosis is caused predominantly by bad things happening to people and (2) prefer psychosocial treatments to medical ones.

In the years ahead of us ISPS members will disagree about how to handle the challenges I have identified. We will disagree, too, about which is the 'best' psychological approach to psychosis (a fun but futile debate since different people require different approaches). We will disagree about other things, including, I am sure, the name of the organisation (which I would like to see be something like the International Society for Psych-social Approaches to Psychosis). I am so grateful, however, to have found an organisation that is having such discussions and disagreements. I know the future of the ISPS is secure because I have met so many people who are willing to put their time and energy into making sure that this is so. I only wish I could have met all those who went before them.

notes:

1. *This chapter expresses my personal views and not those of the ISPS Executive Committee of which I am currently a member*
2. *Rather than provide specific references I have listed some of the many books that adopt a similar perspective to my own and/or provide research evidence for arguments or statements I have made in this chapter*

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FIFTY YEARS OF HUMANISTIC TREATMENT OF PSYCHOSES

In Honour of the History of the International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses, 1956 - 2006.

PART IV: ANNEXES

I. The ISPS Constitution

(With minor changes approved by the ISPS general assembly June 7, 2000)

ARTICLE 1

TITLE

The name of the organisation shall be THE INTERNATIONAL SOCIETY FOR THE PSYCHOLOGICAL TREATMENTS OF THE SCHIZOPHRENIAS AND OTHER PSYCHOSES hereafter referred to as "The Society".

ARTICLE 2

LEGAL STATUS

The Society will be an international society governed by the law of Norway.

ARTICLE 3

OFFICIAL LANGUAGE

The English text of the Constitution of the Society shall be the official text.

ARTICLE 4

The formal address for all communications shall be that of the appointed Secretariat of ISPS of that time.

ARTICLE 5

OBJECTIVES OF THE NETWORK

5.1a to promote the appropriate use of psychotherapy and psychological treatments for persons with schizophrenias and other psychoses.

- 5.1b to promote the integration of psychological treatments in treatment plans and comprehensive treatment of all persons with schizophrenias and other psychoses.
- 5.1c to promote the appropriate use of psychological understanding and psychotherapeutic approaches in all phases of the disorders including both early in the onset and in longer lasting disorders.
- 5.1d to promote research into individual, group and family psychological therapies, preventative measures and other psychosocial programmes for those with psychotic disorders.
- 5.1e to support treatments that include individual, family, group, and network approaches and treatment methods that are derived from psychoanalysis, cognitive-behavioral, systemic and psycho-educational approaches.
- 5.1f to advance education, training and knowledge of mental health professionals in the psychological therapies and psychosocial interventions in the treatment and prevention of psychotic mental health disorders for the public benefit regardless of race, religion, gender or socio-economic status.

In pursuance of the above objectives the Society shall have the following powers:

- 5.2a to promote an International Executive Committee structure for the Society to support continental, regional and national networks of professionals that will aim to fulfill the objectives in 5.1
- 5.2b to enhance awareness amongst professionals, administrators and legislators in the public sector about the psychological therapies and psychosocial interventions and to make available to the general public knowledge of such therapies and interventions and where so, to bring to the public's attention the scarce availability of such therapies and interventions
- 5.2c to facilitate communication amongst mental health professionals administrators and legislators worldwide, by means of publications, newsletters, journals, scientific conferences and other meetings.

- 5.2d to create a central institution for the collection, provision, maintenance and spread of information and knowledge of the psychological therapies and psychosocial interventions relevant to psychotic disorders.
- 5.2e to establish, carry on, promote, organise, finance and encourage the study, writing, production, publication and distribution of books, periodicals, monographs, pamphlets, articles and other literature and to arrange meetings and lectures and to arrange for the reading of papers and holding of seminars or discussions and to circulate any periodicals and literature that may be deemed advisable by the Executive Committee and to provide library facilities.
- 5.2f: to purchase, take on, lease or hire or otherwise acquire, real or personal property and rights or privileges and to construct, maintain and alter buildings;
- 5.2g: subject to such consents as may be required by law, to sell, let, mortgage, dispose of or turn to account all or any of the property or assets of the Society.
- 5.2h: to undertake and execute any charitable trusts which may lawfully be undertaken by the Society.
- 5.2i: to borrow or raise money on such terms and on such security as may be thought fit provided that the Executive Committee shall not undertake permanent trading activities in raising funds for the said objects;
- 5.2j: to establish and support or aid in the establishment and support of any associations or institutions in accordance with the aims in ARTICLE 5.1 and to subscribe or guarantee money for charitable purposes.
- 5.2k: to join or affiliate or cooperate with and subscribe to any association, society or corporation and to purchase or otherwise acquire and undertake all or any part of the property, assets, liabilities and engagements of any such association, society or corporation.
- 5.2l: to do all such other things as shall further the said objects or any of them, but not to do anything which will breach the national law of a member state.

ARTICLE 6

MEMBERSHIP

Membership shall be open to all individuals, groups and organisations of mental health professionals, administrators and legislators upon payment of the subscription fee. The executive committee has the absolute power to exclude from membership persons that it considers would not benefit the organisation and its objectives. Membership is not indicative of, and must not be used to indicate any form of professional competence or expertise.

ARTICLE 7

THE EXECUTIVE COMMITTEE OF THE SOCIETY

- 7.1 The affairs of the Society shall be managed by an International Executive Committee.
- 7.2 The Executive Committee will be composed of up to eight members who will be elected by ballot in conjunction with a Formal General Meeting of the Society for a maximum period of 4 years before further elections must take place.
- 7.3 There shall be no restriction on the number of terms of office for which an Executive Committee member may be elected.
- 7.4 THE CHAIRPERSON shall be elected from amongst the Executive Committee members and by the Executive Committee members at its first meeting following their election at a Formal General Meeting. Other Executive members will be appointed by the Executive Committee itself to the positions needed for its functioning. These shall include a treasurer and a secretary and minutes shall be taken of all meetings and decisions made.
- 7.5 Members of the Executive Committee may resign by giving notice in writing to the secretary.
- 7.6 The proceedings of the Executive Committee shall not be invalidated by any failure to appoint or by any defect in the appointment of any member.

- 7.7 The Executive Committee shall be convened at least annually by the chairperson. An official convening may take the form of telephone or video conference meetings involving a quorum of members. A quorum shall be at least four elected members. Additional meetings must be called by the chairperson if at least four Executive Committee Members sign a letter expressing a request to meet.
- 7.8 The Executive Committee shall appoint an organisation or committee to be responsible for THE ORGANISATION of the recommended triennial symposium of the network. This committee shall be accountable to the Executive Committee
- 7.9 The Executive Committee may from time to time appoint such sub-committees as may be deemed necessary, and may determine their terms of reference, powers, duration and composition, provided that all acts and proceedings of any such sub-committee shall be fully and promptly reported to the Executive Committee.
- 7.10 The Executive Committee shall have the power to appoint and dismiss a paid secretary and such other employees of the Society, not being members of the Executive Committee as it may from time to time determine, or to arrange with any other organisation for the provision of secretarial and administrative services.
- 7.11 The Executive Committee shall have the final authority to determine membership of the Society.
- 7.12 The Executive Committee shall take its decisions by a simple majority of those present and voting at official meetings. In the event of a tie, the chairperson will have an extra casting vote.
- 7.13 The Executive Committee has the power to make 'Honourary Life Member Awards' for up to a total of twelve living persons who have made outstanding professional contributions to activities that correspond to the Objectives of the Society.

ARTICLE 8

FORMAL GENERAL MEETINGS

- 8.1 The Executive Committee must call Formal General Meetings of the network which must take place at least every four calendar years.

- 8.2 At the Formal General Meeting the business shall include the election of the Executive Committee and consideration of a general report of the Executive Committee and the accounts.
- 8.3 At least one year prior to elections, the Executive Committee shall appoint from amongst itself a nominating committee of at least four persons. In forming this committee the Executive Committee shall be mindful of the need for both geographical representation and experience of the International Society.
- 8.4 Mindful of 8.3 above, the Executive Committee will resolve upon the method of voting in respect of elections to the Executive Committee and any other major agenda items at any Formal General Meeting.
- 8.5 Notification of elections and their date and place shall be given by post to all members, to be posted at least five calendar months before the election. The closing date for receipt of nominations and items for the agenda (which may only be sent by mail or facsimile) shall be three calendar months before the date of election. Agenda items will only be considered from ISPS Members subscribing members.
- 8.6 All nominations must be proposed and seconded by subscribing Society members and may be accompanied by a supporting statement.
- 8.7 The list of nominees and a provisional agenda and information as to the form in which voting will take place must be sent to subscribing members at least one clear calendar month before the Formal General Meeting.
- 8.8 Though it is permissible for there to be more than two nominations from members resident in the same country, no more than two members whose usual residence is in the same country in the year of election may be elected to the Executive Committee. With this exception the (up to) eight nominees with the greatest number of votes shall be elected to the Executive Committee. In the event of a tie for the final places, the other members of the New Executive Committee will vote between those tied persons for the final place(s).
- 8.9 All other decisions at a Formal General Meeting shall be decided on the basis of a simple majority of votes cast.

ARTICLE 9

FINANCES

- 9.1 The Executive Committee shall have power to obtain, collect and receive money and funds by way of contributions, donations, subscriptions, deeds of covenant, legacies, grants or any other lawful method, and to accept and receive gifts of property of any description.
- 9.2 The Executive Committee shall determine the level of subscriptions and the METHODS OF PAYMENTS and require payment of fees within such time as the Executive Committee shall determine but not less than one month from the demand. No person shall be entitled to vote if that person has not paid his dues within a period of SIX months following demand. The Executive Committee shall also have the power to expel a person or organisation for non payment of fees.
- 9.3 The income and property of the Society, whencesoever derived, shall be applied solely towards the object of the Society as set forth in ARTICLE 5 and no portion thereof shall be paid or transferred directly or indirectly by way of dividend, bonus or otherwise howsoever by way of profit to any member of the Executive Committee: provided that nothing herein shall prevent the payment in good faith of reasonable and proper remuneration to any servant of the Executive Committee not being a member of the committee, or the repayment to members of the Executive Committee or any sub-committee appointed under ARTICLE 9.10 hereof of reasonable and proper out of pocket expenses.
- 9.4 The financial year shall run from 1st January to the 31st December.
- 9.5 The funds of the Network including all donations contributions and bequests, shall be paid into an account operated by the Executive Committee in the name of the Society at such bank as the Executive Committee shall from time to time decide. All cheques drawn from the account must be signed by at least two persons authorised by the Committee, at least one of which must be an Executive Committee member.

ARTICLE 10

DISSOLUTION

The Society may be dissolved by a Resolution passed by a two-thirds majority of those present and voting at a Special General Meeting convened for the purpose of which at least 21 days notice shall have been given to the members.

Such resolution may give instructions for the disposal of any assets held by or in the name of the Society, provided that if any property remains after the satisfaction of all debts and liabilities, such property shall not be paid or distributed among the members of the Society. Such assets or property but shall be given or transferred to such other charitable institution or institutions having objects similar to some or all of the objects of the Society as the Society may determine. If and in so far as effect cannot be given to this provision then to some other charitable purpose

ARTICLE 11

AMENDMENTS TO THE CONSTITUTION

Alteration to this Constitution shall receive the assent of two-thirds of the members present and voting at a Formal General Meeting or a Special General Meeting. A resolution for the alteration of the constitution must be received in writing by the Secretary of the Society at least four months before the meeting at which the resolution is to be brought forward. At least two calendar months clear notice of such a meeting must be given in writing by the Secretary to the membership and must include notice of the alteration proposed.

II. History of ISPS Board members 1990-2006

ISPS Board members 1990-1997 (Unofficial)

Yrjö Alanen, Finland
Endre Ugelstad, Norway
David Feinsilver, USA
Torleif Ruud, Norway,
Johan Cullberg, Sweden
Brian Martindale, UK
Per Maria Furlan, Italy

ISPS Board members 1997-2000

Johan Cullberg, Sweden (Chair)
Pier Maria Furlan, Italy
Courtenay Harding, USA
Jan Olav Johannessen, Norway
Brian Martindale, UK
Patrick McGorry, Australia
Franz Resch, Germany
Torleif Ruud, Norway

ISPS Board members 2000-2003

Jan Olav Johannessen, Norway (Chair)
Johan Cullberg, Sweden
Courtenay Harding, USA
Brian Martindale, UK
Patrick McGorry, Australia
Franz Resch, Germany
Torleif Ruud, Norway
Ann-Louise Silver, USA

ISPS Board members 2003-2006

Jan Olav Johannessen, Norway (Chair)

Brian Martindale, UK

Patrick McGorry, Australia

Manuel González de Chávez, Spain

Ann-Louise Silver, USA

Ivan Urlic, Croatia

Lyn Chua, Singapore

John Read, New Zealand

Torleif Ruud, Norway

III. ISPS Life Honorary Members

Yrjö O. Alanen, by Manuel González de Chávez

Gaetano Benedetti, by Brian Koehler

L. Bryce Boyer, by Sue von Baeyerer

Johan Cullberg, by Sonja Levander

Stephen Fleck, by Ann-Louise S. Silver

Murray Jackson, by Brian Martindale

Jarl Jørstad, by Svein Haugsjerd

Julian Leff, by Brian Martindale

Theodore Lidz, by Ann-Louise S. Silver

Christian Müller, by Luc Ciompi

Barbro Sandin, by Kia Sjöström

Harold F. Searles, by Ann-Louise S. Silver

Helm Stierlin, by Michael Wirsching

John S. Strauss, by Ann-Louise S. Silver

Endre Ugelstad, by Torleif Ruud

Lyman C. Wynne, by Susan McDaniel

Yrjö O. Alanen



Yrjö Alanen is one of the professionals who have helped shape the history of schizophrenia, its understanding and its global, flexible approach adapted to the needs of patients.

Professor of Psychiatry (Emeritus) Yrjö Olavi Alanen was born Jan. 31, 1927 in Kurikka, Finland. He got his M.D. degree in the University of Helsinki in 1952 and did his specialist training in psychiatry and neurology in the Psychiatric University Hospital in Helsinki from 1954 to 1957. He was appointed to senior level clinical positions in this hospital from 1958 to 1968, after which he was appointed Professor of Psychiatry and Chairman of the Department of Psychiatry at the University of Turku, Finland. This position also included the chairmanship of the Department of Psychiatry and clinical work as Medical Director of the university hospital The Clinic of Psychiatry of Turku. He retired in 1990, however, since then he has continued his professional work as a psychotherapist and teacher, dedicating more time than previously to writing and editing books in his field.

Alanen had already begun his personal psychoanalysis in 1955 and was one of the first candidates for psychoanalytic training after IPA training became possible in Finland in 1965. He became a member of the Finnish Psychoanalytic Association in 1969. His main interests have been the psychodynamic study of schizophrenic psychoses and individual and family psychotherapy of schizophrenic psychoses. He instigated the first regular family therapy training in Finland in 1979 and acted as a member of the first trainer group in family therapy. This training soon became very popular and more extensive in different parts of Finland because, among other things, of its multi-professional quality. Family therapy training was also later established at an advanced special level. In the 1990s Alanen joined his closest working pupils and co-workers Viljo Rökköläinen and Jukka Aaltonen in the establishment of the advanced special level training program in psychodynamic individual therapy of seriously disordered patients.

Among other things, Alanen's early studies dealt with family environments and dynamics of schizophrenic patients, leading to the monographs *The Mothers of Schizophrenic Patients*, 1958; and (together with co-workers)

Family in the Pathogenesis of Schizophrenic and Neurotic Disorders, 1966. These studies already included features of integrated views, typical to Alanan's later theoretical and clinical ways of thought. In 1959-60 he was Research Associate in Yale University Dept. of Psychiatry in New Haven, Conn., U.S.A., working in Theodor Lidz's team. In 1979 he received the seventeenth annual Stanley R. Dean Research Award, given by The American College of Psychiatrists and The Fund for the Behavioral Sciences in recognition of basic research accomplishment in the behavioural sciences contributing to our understanding of schizophrenia.

In 1971, Yrjö Alanan organized the IVth ISPS symposium, held in Turku, Finland. After that, he was a member of the international executive committee of the ISPS until 1997. He is a lifetime honorary member of the ISPS.

In Turku, Alanan, along with his co-workers, established the Turku Schizophrenia Project, which led to the development of the now well-known need-adapted approach, an integrated and individualized psychotherapeutically oriented treatment of schizophrenic patients, leading to several later projects and practice in Finland and in the other Scandinavian countries. This approach and its results are presented in Alanan's major work, the book *Schizophrenia – Its Origins and Need-Adapted Treatment* (London: Karnac, 1997), which has also been published in Finnish (1993), German (2001), Polish (2001), Spanish (2003) and Italian (2005). During the 1980s, he was the leader of The Finnish National Schizophrenia Project, which aimed for a more psychotherapeutic and humanistic treatment of psychotic patients. According to the follow-up in 1992, both the amount of "new" and "old" long-term schizophrenic patients in Finnish mental hospitals had diminished about 60 per cent over 10 years. In the 1980s and '90s Alanan also led, together with Endre Ugelstad and other Scandinavian colleagues, the NIPS (Nordic Investigation on Psychotherapy of Schizophrenia) project, aiming to promote psychodynamically oriented study and treatment of new schizophrenic patients within the community psychiatric context (cf. the book Alanan et al.: *Early Treatment for Schizophrenic Patients; Scandinavian psychotherapeutic approaches*; Oslo: Scandinavian University Press, 1994). He is also one of the editors of the book *Psychotherapie der Psychosen; Integrative Behandlungsansätze aus Skandinavien* (V. Aderhold et al., eds, Giessen: Psychosozial-Verlag, 2003).

In 1982-84 Alanan acted as the chairman of the Committee of Mental Health in Finland, aiming at the innovation of the activities to a more open care-oriented direction and to end the separation of psychiatric

organizations from the organizations including other medical specialties. The proposals of the Committee led to a new Mental Health Act, enacted in 1991, after the establishment of an Act joining the organizations for special health care together. From 1982 to 1985 Alanen also held the position of Research Professor, Academy in Finland, coinciding with his work as the leader of the National Schizophrenia Project.

Yrjö Alanen is an honorary member of 9 scientific and/or professional societies, including – besides the ISPS – the Finnish, Swedish and Polish Psychiatric Associations and the European Family Therapy Association. His special interests have included cross-country skiing and still include, especially, literature (he has published two essay books in Finnish, one of them dealing with Dostoyevsky's *The Idiot* and *The Devils*). He is married to Johanna, née Aalto, has four children and six grandchildren.

Yrjö Alanen has had a complete life of lucidity, dedication and devotion. He investigated the familial dynamics of psychotic patients while establishing the most effective familial and individual psychotherapeutic strategies and interventions and the global health care devices that these patients require for their recovery. He took charge of the psychotherapeutic training of all the professionals, of the creation of early psychotherapeutic and familial intervention teams, of the development of integrated therapeutic programs and of the investigation of the results of these programs on improvement or overcoming of psychotic disorders.

From the city of Turku to the rest of Finland, from Finland to the other Scandinavian countries and to many other parts of the world, the figure and the work of Yrjö Alanen has had a decisive influence and has been a great example for many professionals in our field.

Manuel González de Chávez

Gaetano Benedetti



Professor Gaetano Benedetti noted:

“Over half century of psychodynamic research has proved that schizophrenia is not only a medical disorder, but a biographical facet of the human being-it is a challenge to the whole of society to understand, accept and reintegrate the psychotic patient amongst us.”

(Ninth International Symposium on the Psychotherapy of Schizophrenia)

“It is in the psychotic’s suffering that the most serious problems of the human mind are encountered. Tackling them means illuminating the human being with signification and sense, gaining a better understanding of the human being in general, not only of the psychotic person.”

(Tenth International Symposium for the Psychotherapy of Schizophrenia)

Gaetano Benedetti was born in 1920 in Catania, Sicily. He joined the psychiatric staff at the Zurich University Clinic Burghölzli in Switzerland in 1947, where he increasingly focused his work on the psychoanalytic psychotherapy of psychotic patients. He worked closely with Gustav Bally, Medard Boss, Marguerite Sechehaye, and Christian Müller. Benedetti and Müller co-founded the International Symposium for the Psychotherapy of Schizophrenia (ISPS) in 1956 at the psychiatric clinic at the University of Lausanne in Switzerland.

The ISPS has evolved into the currently thriving International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses (www.isps.org and www.isps-us.org). The impetus for founding ISPS was Benedetti and Müller’s dissatisfaction with the predominantly reductionistic orientation of European psychiatry and they had sought the aid of psychoanalysis to find a different approach to the schizophrenias.

In 1956, Benedetti was also appointed professor of psychotherapy at the University of Basel. He continued his work with persons diagnosed with schizophrenia until he retired in 1985. However, Professor Benedetti remains active into the present in his teaching and supervision of clinicians engaged in psychosis psychotherapy. His favorite book has been translated into many languages, in German it is called “Todeslandschaften der Seele”

(1998), and in Italian, "Alienazione E Personazione Nella Psicoterapia Della Malattia Mentale" (1980). His collected papers were published in English under the title "Psychotherapy of Schizophrenia" in 1987 by New York University Press. Professor Benedetti has published a multitude of articles covering such topics as gender differences in psychosis psychotherapy, the use of a therapeutic assistant, emergency interventions in psychotic crises, facilitating factors in psychosis psychotherapy, the ego structure and self-identity of the person with schizophrenia and the task of psychoanalysis, and mirror-image experiences in psychosis psychotherapy.

Benedetti moved psychoanalysis with psychotic persons away from the primary emphasis on transmission of cognitive insight, to the transmission of therapeutic transforming images, of transitional subjects, of mirror phenomena, of patient-therapist symmetries, of therapeutic dreams, of progressive psychopathology. He believes that our concept of psychosis psychotherapy must be broad enough to include our psychological concern for the schizophrenic human being as differentiated from, but not divorced from the study of the neurobiological processes observed in schizophrenia. Benedetti sees therapeutic transforming images as arising from the therapist's ability to identify with the catastrophes occurring within the patient, to live them as if they were our own, to the point in which the therapist's latent psychotic nuclei may be mobilized. However, these become part of the dialogic interweave, which is 'antipsychotic.' The therapist's containment and consubstantiability with the negative, anxiety-ridden, aspects of the patient helps the latter to gain awareness of the positive aspects of her or his self. It is then that the "transitional subject" emerges within the unconscious or conscious mental processes of both patient and therapist. This also signifies that a "progressive psychopathology" is proceeding, in which previous psychopathological phenomena, such as transivism and appersonation, become therapeutically transformed, e.g., a patient may still hallucinate, but the hallucination may be an empathic, correct interpretation of the patient's situation.

Recently, in describing the role of the therapeutic symbiosis, Benedetti commented:

"The dynamic of symbiosis is based upon transference and countertransference; special however is the kind of object, caused by the therapeutic setting, to which the self of the patient relates. The object here is a therapeutic one. This means, basically, that it does not 'invade' the patient's self with its own wishes, demands and expectations, but mirrors back his own positivized image. The fragile psychotic ego is not confronted with demands and fragmented by a

stranger. It encounters itself, its own healing origin, in the positivizing mirror of the therapist" (personal communication).

For Benedetti, delusions are a sort of existential truth for the patient. Therapists allow themselves to be pulled into the delusion in order to stand in the same place as the patient before confronting the patient with her or his delusions. By this, one gains a kind of citizenship within the closed world of the patient. The less dangerous, non-fragmenting therapeutic object is gradually experienced by the patient as a kind of second self, which helps the patient withstand panic and feelings of helplessness. Therapeutic devotion is experienced by the patient as a "niche" for her or his own identity. Paradoxically, Benedetti believes, that only the deep experiencing of symbiosis between patient and therapist can lead to the overthrow of symbiotic confusion in the patient. Most recently, Professor Benedetti is concerned with negative and positive self-images, therapeutic mirror-images, self-objects and transitional subjects in the dreams and in the imaginations of psychotic patients.

Benedetti's influence on European psychosis psychotherapy has been very great, especially in Italy and Switzerland and in the Northern European countries as well. For the past almost 20 years, Benedetti has collaborated with his colleague Maurizio Peciccia. In 1986 they developed a psychotherapeutic method referred to as "progressive mirror drawing." Benedetti and Peciccia hypothesized that the core psychological deficits in schizophrenia are two incompatible nuclei of the self. One is characterized by excessive symbiotic needs and the other by excessive needs for separation which can take on autistic-like coloring. There is a de-integration of the separate and symbiotic selves in schizophrenia. Psychosis psychotherapy, according to this model, is oriented towards an integration of the symbiotic (interdependent) and separate (autonomous) selves.

Between 2000 and 2005 Benedetti and Peciccia have, according to the latter, "extended the principle of symbiotic/separate self integration and sensorial integration not only to psychotherapies but also to the rehabilitation of psychotic patients using new techniques in new therapeutic contexts" (personal communication, Maurizio Peciccia).

Brian Koehler

L. Bryce Boyer

1916-2000

*"The analyst must have the courage to speak
the truth and to hear the truth"*

L. Bryce Boyer.



Bryce Boyer was a brilliant and intuitive clinician, a dedicated psychoanalyst, and a cantankerous and much beloved teacher. He spent most of his professional life working analytically with seriously disturbed patients, imposing very few changes in the analytic frame while so doing. Although thoroughly trained in ego psychology, Dr Boyer developed a different theoretical orientation as he worked with patients struggling at the level of narcissistic neurosis. He was among the pioneers who relied on countertransference information to understand the early, perhaps even somatic, communications of his patients. Working at the pre-oedipal level in those early days also involved some difficulty with the psychoanalytic establishment who, at that time, thought that the analyst should respond only to verbal communications and that those verbal communications and interpretations should be at the oedipal level. In his later years, he appreciated the validation that came with the influx of psychoanalysts who were eager to learn about using countertransference information. Dr. Boyer wrote and taught extensively in the area of working psychoanalytically with the regressed patient. He also wrote about, and was deeply interested in, the Rorschach test especially in relation to other cultures. For many years he studied the Mescalero Apache Indians, along with his wife Ruth, who was an anthropologist. Dr. Boyer authored and co-authored, edited and co-edited numerous books, including *Psychoanalytic Treatment of Schizophrenic, Borderline, and Characterological Disorders*, 2 editions; *The Regressed Patient*; *Technical Factors in the Treatment of the Severely Disturbed Patient*; *Childhood and Folklore: A Psychoanalytic Study of Apache Personality*; *Master Clinicians on Treating the Regressed Patient*, Vols. 1 and 2; Vols. 7-19 of *The Psychoanalytic Study of Society*; *A Rorschach andbook for the Affective Scoring System*, 3 editions; and numerous articles. Many of his books and articles have been translated into such languages as German, Italian, Spanish, Portuguese, Norwegian, and Finnish.

In terms of his personal biography, Dr. Boyer was always quite frank and

revealing about his early life. Dr. Boyer's mother was severely disturbed and paranoid. Dr. Boyer has often attributed his capacity to understand and interpret regressed patients at a visceral level to the necessity of understanding and interpreting his mother. He has also attributed to his mother the development of the belief that the acting out behavior of seriously disturbed patients is not merely resistive, but is also an effort to communicate and recall experiences for which these patients do not as yet have words. Because his mother could respond to his interpretations, and they would calm her, his conviction grew that narcissistic disorders could be treated by psychoanalysis. Dr. Boyer encountered several significant colleagues as he trod what must have been a lonely path in those early days of treating severely disturbed patients psychoanalytically. He struck up a friendship and a productive collaboration with Peter Giovacchini, M.D., starting in 1967. Dr. Giovacchini once wrote to Dr. Boyer that "We grew up together" (personal communication to LBB) as they wrote and edited their way collaboratively through many volumes of psychoanalytic articles. Another colleague who was very important to Dr. Boyer was Tom Ogden, M.D. They first met in the context of a psychiatric teaching hospital, and went on to form the Center for the Advanced Study of the Psychoses. The Center, along with other endeavors, included a study group where psychoanalysts and psychotherapists presented difficult cases involving difficult patients. Dr. Boyer sat at one end of the table and Dr. Ogden at the other. The understanding of the patients presented unfolded in the discussion around the table and in the back and forth between Drs. Boyer and Ogden. The participants also read and discussed the writings of Bion, Winnicott, Klein among others. This was a rich environment for learning what was previously thought to be unteachable. Another major topic of conversation at that table was the absolute interdependence of transference and countertransference. Many a case presentation found resolution when the understanding developed of the mutual introjections by the analyst and the analysand of each other's unconscious or preconscious projective identifications, a major teaching of Dr. Boyer. In 1982, a grateful former patient of Dr. Boyer donated a sum of money in Dr. Boyer's name to establish a treatment center. The Boyer House Foundation took shape. This treatment center continues to this day, with well-trained staff working psychoanalytically in a residential, long-term, open, therapeutic community. The staff works diligently to understand the patients through the countertransference, sometimes coming together in the weekly case conference like slices of a pie becoming whole again, as each therapist brings forward his/her countertransference based understanding of the patient in question. As the staff each represents an individually apprehended fragment of the patient, the patient comes together representationally, taking on a fuller,

more complete understanding in the therapeutic community and the work becomes stronger. We were taught well by Dr. Boyer and his work lives on. We are grateful.

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Sue von Baeyer

Johan Cullberg



It is difficult to find a perspective that will catch the scope of what has constituted Johan Cullberg's professional life – thus far. Every aspect seems to touch upon the other.

He started his career at the department of gynaecology at the Karolinska Hospital: The psychological effect of contraceptive pills. Somewhat later he interviewed 60 women who had lost their child during delivery, a study which he used for his dissertation. These narratives from women in crisis helped him to fully understand that it is not only a painful period that has to be lived through. It is also, in fortunate cases, a starting point for a process of maturation that opens up for insights not available previously. This experience is described in his book: "Crisis and maturation," which was published in 1975, a book which has contributed to the general understanding of the crisis experience. He points to the importance of coming to a stand still to be able to look at the catastrophe in a personal life context. Many unfortunate individuals will eventually come out as stronger and more mature persons.

At that time Johan Cullberg also became the head of one of the outpatient clinics in the Nacka project, one of the first areas in Sweden to focus on psychiatric care outside the hospital. He took special interest in the interplay between the individual patients and their close environment. Medicine and hospital care came second, and normalization was at the centre of his interests. Later he became the head of the research unit of the project where he more systematically studied the environmental effects on mental health. He wrote about the anomic milieu; its alienating effects and how it tends to deprive people from getting enough confirmation of their human dignity to allow them to go on. Most people who live in a suburban environment find ways to overcome this, but it is harmful for those who are vulnerable. Johan Cullberg wanted to understand what conditions in society have to be changed to make the interaction more positive.

During these years he was also engaged in the situation for the patients who had to be confined in the hospital ward – especially those who suffered from

psychosis. This had a special meaning for Johan Cullberg as one of his brothers became schizophrenic and was locked in a hospital ward and treated with hundreds of electroconvulsive shocks and insulin treatments. Even if his brother in many respects faded away slowly as a person, he is still active and recognized for his artistic painting. Having lived with this pain for the main part of his life, Johan has fought for a more decent treatment of psychotic patients. He has claimed the need for lower doses of antipsychotic medicine and a reduction in the use of compulsory treatment. On the whole he has wanted the psychiatric care to take a more humane direction.

Of course it has kindled a hope in many patients and their families, when a person from the psychiatric establishment took sides with the patients: But the disappointment has been equally strong, when it turned out that he had kept his belief in neuroleptic treatment in adequate doses and in the existence of biological factors as the main determinants of schizophrenia – even if he is a psychoanalyst. For him the psychodynamic understanding is indispensable, but it is not really an alternative when it comes to the treatment of psychotic patients. What we read about in the literature are single case reports that he believes are exceptional.

He has discussed his opinion that it is necessary to integrate the biological with the psychodynamic approach in open debates and in the scientific press. But the ambivalence to his integrative endeavours has appeared when at times his contributions have been passed over in silence or have been considered unrealistic. This was particularly clear when they were nominating a candidate for a professorship, which according to many people was intended for Johan Cullberg, and he was disregarded. Many were very upset. When asked about it Johan himself thinks that the academic debate in Sweden is polarized and simplified. (Some ten years ago, however, he was awarded an honorary professorship).

During the eighties and the beginning of the nineties he worked clinically at the same time as he continued formulating his experiences in writing. It was for him a matter of course to convey to others what he had seen and thought about psychiatric conditions, their background and treatment. First of all medical students have been his target group, as he sees them as central when it comes to a change of Swedish psychiatry. He wanted to write study literature from the subjective and objective perspective as well as the biological, the psychological and social, each being the necessary condition for the others.

His next book, "Dynamic Psychiatry", is a far-reaching textbook that covers psychiatry as a whole. At the same time it introduced a personal vignettes including empathy and understanding, it gives directions as to medication and diagnostic considerations.

The following book, "Psychoses," is as exciting as a novel, and has surely tempted many students to start working in psychiatry. He gives psychodynamic explanations of the background to the psychotic condition, and demonstrates how the compulsory measures can be replaced by respect and kindness. But it also leaves space for much that is still to be understood about these conditions, especially the vague concept of schizophrenia, which probably covers a lot of different states of mind.

Later he widened his perspective to the literary field and has written two so-called psychobiographies. In his eagerness to try to understand more about the psychotic process, he grappled with three Swedish authors: Stig Dagerman, who committed suicide, and August Strindberg and Gustaf Fröding both of whom became psychotic. From a psychodynamic perspective he reads their texts, supplementing them with outside information about their lives and excerpts from their psychiatric files. In describing their existential situations he digests it into portraits of human beings of flesh and blood, who in their literary works have tried to understand their problems.

The last ten years of research have been dominated by his work with the "Parachute Project" – an expression of his wish to understand what factors are of importance for the psychotic break down and for the outcome. First of all, however, he wanted to demonstrate that it is possible to make psychiatric care more humane by considering the patients' individual needs. Important research questions have been: What distinguishes those of the 175 patients who had a good outcome from those who never were able to return to their prepsychotic life? And what did it mean to them that instead of noisy and messy hospital wards they stayed in quiet, small, homelike units – mostly outside the hospital? Especially he wanted to find out the consequences of offering lowest effective doses compared to minimizing symptoms by using high doses of antipsychotics, often with heavy side effects. The project is going to be presented at the ISPS conference in Madrid 2006.

Johan Cullberg has said that more and more he has adopted a view of the human being as one who has to take responsibility for her life, irrespective of her psychological problems. After all, one has to believe that no one can

change another person who is not willing to change. What kind of life does our patient want to live? What kind of person does she want to be? Those of us who have chosen to try to help those who seek our help, first of all have to support her in reaching the goals she has set for herself. We are not there to cure or correct other people to make them fit our model for a normal person.

Sonja Levander

Stephen Fleck



Stephen Fleck died on December 19, 2002, maintaining his friendship with Theodore Lidz to the end, both of them living in the same retirement home in New Haven, Connecticut. An emeritus professor in two departments at the Yale University: psychiatry and the department of epidemiology and public health, he was the epitome of a gentle yet firm mentor for his younger colleagues, maintaining these ties as well, almost to the end. He and Ted Lidz began working together in the late 1940s. They succeeded in pushing psychoanalytic orientations from a two-person study of the individual to a perspective including social-scientific methodology, medical, behavioral, neurological and public health factors. They emphasized familial factors. Their research family was also innovative in its diversity, including all the mental health specialties, and avoiding narrow elitism. The papers issuing from this team's work were published in the landmark *Schizophrenia and the Family*, published in 1965 by International Universities Press, and edited by Lidz, Fleck and Alice Cornelison. Number 7 in IUP's Monograph Series on Schizophrenia, it delineated the twelve years of conducting an intensive study of the interfamilial environment in which schizophrenic patients grew up.

In 1980, he co-edited *Psychotherapy of Schizophrenia*, whose senior editor was John Strauss, along with T. Wayne Downey. The book was published by Jason Aronson. And in 1981, with Jerzy Henisz, he co-authored *Psychotherapeutic Management on the Short-Term Unit: Glimpses at Inpatient Psychiatry*. He participated in the writing of "Practice Parameters for the Assessment and Treatment of Children and Adolescents with Conduct Disorder," issued in 1997 by the American Academy of Child and Adolescent Psychiatry.

Fleck was born on September 18, 1912 in Frankfurt, Germany. As a medical student in 1933, he and others were told by one of their professors that the Nazis had marked them for arrest. He fled first to Holland and in 1935 he moved to the United States. By 1940 he had graduated from Harvard Medical School. There, he served as John Rock's research assistant and thus contributed to the basic research that led to the birth-control pill. Fleck maintained an interest in this initiative, working on the American Psychiatric

Association's Family Planning Position Statement, No 73007, in 1973, chaired by Eugene Brody, M.D. "Individual choice as to whether and when to become a parent and the prevention of unwanted pregnancy or birth is an important way to promote and safeguard the health and welfare of individuals, families, and communities. Birth control, including contraception, medically safe abortion, and voluntary sterilization should therefore be available universally to every individual on request to prevent unwanted pregnancy or parenthood as a part of standard health care and medical services." He along with his wife, Louise, worked politically towards the ultimate success on June 7, 1965 of the landmark case *Griswold v. Connecticut*, which made the sale of birth control legal in the state. By a vote of 7 to 2, the Supreme Court of the U.S. ruled that the Constitution protected a right to privacy. Justice William O. Douglas, writing for the majority, ruled that this right was to be found in the "enumbras" of other constitutional protections. One can imagine the victory parties the Flecks hosted and attended, and the joy they felt in a nation protecting its citizens so fully.

From 1942 to 1946, Fleck served in the Army Medical Corps stateside and in Europe, sometimes also assisting Army intelligence. Following the Battle of the Bulge, he was briefly in charge of 80,000 German POWs, most of them medically ill. In May 1945, he helped evacuate and treat concentration-camp prisoners and interrogate German prisoners. He also searched concentration camp records for signs of his own family and friends who had not escaped Nazi arrest.

Following the war, he completed a psychiatric residency at the Henry Phipps Clinic of the Johns Hopkins Hospital in Baltimore, Maryland. He then served from 1949 until 1953 on the faculty of the newly founded University of Washington Medical School, where he received psychoanalytic training. In 1953 he joined the Yale Department of Psychiatry, helping begin the long-term research project on schizophrenics and their families. At Yale, he served in numerous administrative capacities, including Psychiatrist-in-Chief of both the Yale Psychiatric Institute (1953-83) and the Connecticut Mental Health Center (1969-83); Director of Residency Training; and Deputy Chair (1969-83). His Yale obituary notes, "Despite an extensive research and publishing record, he always maintained that clinical care and teaching should be first priorities of any academic setting. He refused major administrative positions at several junctures, preferring to concentrate on those priorities," as if thirty years heading the famous YPI were not a major administrative post.

Fleck valued his role in the career development of many psychiatrists and other mental health professionals; he took a deep fatherly interest in them. Even when officially retired, he continued supervisory and professional service until shortly before his death. He and his wife, Louise H. Fleck, who predeceased him, were active community volunteers, focusing on projects to strengthen the public schools as well as to promote reproductive choice. He was survived by daughters, Anna F.J. Singer and Carra F. Rockwood, his son, Stephen H. Fleck, and four grandchildren, and by his brother, Edgar Fleck and dear friend, Dr. Gertrud Hunziker-Fromm of Zurich, Switzerland. I am grateful to Karen Peart for her internet posting of the Yale News Release of Stephen Fleck's obituary, which provided most of the information included here.

Ann-Louise S. Silver

Murray Jackson



Murray Jackson has played a leading role over many decades, in both Britain and Scandinavia, in stimulating and maintaining the interest and skills of many professionals in the contributions that psychoanalytic approaches can make to the treatment of individuals with psychotic illnesses.

Born in Australia in 1922, he graduated in medicine at the University of Sydney in 1945. After Military service in Occupied Japan and a period of medical research in the US he moved to London where he trained in psychiatry at the Maudsley Hospital. In the hey-day of psychoanalytic influence in psychosomatics he was much influenced by the work of psychoanalysts in the field of, in particular that of George Engel and John Romano at the Rochester School of Medicine and of Franz Alexander in Chicago.

Ten years as a psychiatric Consultant in a University Hospital led to a life-long interest in the psychological factors contributing to certain physical illnesses, in particular in those gastro-intestinal disorders which may occasionally reciprocate with psychotic states. Writing about psychosomatics, teaching medical students and trainee psychiatrists, and interest in Jung's work on psychosis led him to training first in analytical psychology and later in psychoanalysis.

Appointed as Consultant at the Maudsley hospital in 1972, he directed a 10-bed unit on 'Ward 6' where psychoanalytic principles were applied to the treatment of a wide range of the severely mentally ill, whilst continuing his private psychoanalytic practice which focused on less severe borderline and psychotic cases. The success of this unit depended on the integration of pharmaceutical, psychological and innovative nursing approaches, together with his psychoanalytically-based 'ward rounds' with patients and staff and active support for the psychological containment offered by the staff – particularly those nurses who went on to further training as 'nurse-therapists'.

Although far from partisan within the psychoanalytic schools, he felt that Melanie Klein and those who followed in her footsteps and developed her

ideas further offered a rich framework that greatly assisted the understanding of the psychotic mind, and he profoundly admired the work of pioneers such as Henry Rey, Donald Meltzer, Herbert Rosenfeld, Hanna Segal and Wilfred Bion.

With the encouragement of Paul Williams, the co-authored book 'Unimaginable Storms: A Search for Meaning in Psychosis' (Jackson & Williams 1994) was published. This outstandingly educative book was based on edited transcripts of audio taped interviews of Murray with patients of the ward. It has been a most important source book for a whole generation of professionals seeking a contemporary psychoanalytic understanding of psychosis, and of the 'psychotic' aspects of their mind.

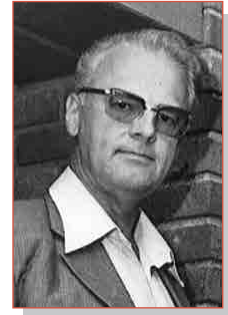
Regrettably the in-patient unit at the Maudsley Hospital was not continued in the same modality after his retirement from the British National Health Service in 1987, but he continued his teaching at a number of centres in Scandinavia over the next 15 years, recording his experience in a second book –'Weathering the Storms – Psychotherapy For Psychosis' (Jackson 2001), a masterpiece of communication illustrating how selected psychotic patients can benefit from non-intensive psychoanalytic psychotherapy conducted by well-trained professionals was largely born out of this experience.

He and his colleague Michael Conran succeeded in persuading younger colleagues to work to bring the ISPS symposium to London in 1997 in order to influence practitioners in the mental health field in the UK and to inform them of the importance of developments in other parts of the world. Although long retired from direct clinical work, he has sustained a great interest in the subject of psychosis. He lives in rural France with his wife Cynthia, his constant companion and support for the 49 years of their marriage.

He was awarded a Life Service Award at the ISPS International Conference in Washington in 1994.

Brian Martindale

Jarl Jørstad



Jarl Jørstad's development as psychiatrist and psychoanalyst was influenced by three months confinement in a solitary cell, and later 18 months prisoner in Germany during the war, when many hundred Norwegian students were arrested. His experiences in the concentration camps Pölitz, Buchenwald and Neuengamme contributed to his growing curiosity about the forces in human minds which create such cruelty and holocaust. He luckily survived and started the medical school in Oslo in 1945, and graduated as MD in 1950, psychiatrist 1958 and psychoanalyst 1972.

His interest in treatment of schizophrenic patients developed during his work in two periods at Dikemark mental hospital, treating severely disturbed and schizophrenic patients from Oslo. During the last 12 years period, when he was head of the department 5 (Lien), together with a dedicated staff, he managed to develop a pioneer institution, trying to combine a therapeutic community with individual psychotherapy, including many young schizophrenic patients. The experiences they had during this period they published in many papers and in the Norwegian TV.

This was one background for the ISPS Symposium in Oslo in 1975. Another important background was also his stay in USA in 1968 – 69, when his main goal was to study the teaching of psychotherapy, at Harvard (Beth Israel Hospital, John Nemiah, Peter Sifneos), Yale (Theodore Lidz), New York, (a.o. Montefiore, Hillside, Jacoby, - Alberta Szalita), and NIMH, Washington D.C. (Helm Stierlin). This created important networks of top professionals in psychotherapy, family therapy and social treatment of schizophrenic patients in USA. The following years many of them came to Norway and gave seminars and taught in many places in Norway. Well known psychotherapists from United Kingdom, Switzerland and Germany (M. Jackson, D. Malan, G. Benedetti, H. Stierlin and many others) also had important seminars.

The successful ISPS Symposium in Oslo in 1975, contributed to this process of increased interest in psychodynamic understanding and treatment of schizophrenic and other psychotic patients all over Norway.

In 1976 Jarl Jørstad was appointed as medical director of the psychiatric university clinic 6 B in Oslo City Hospital Ullevål. This was also a pioneer institution in developing a therapeutic community which included a mixture of neurotic and psychotic patients, and had many groups. A basic condition for their treatment program was that they could select the patients they admitted into the ward, and they favoured more resourceful neurotic patients.

During his leadership he recruited many excellent clinicians and researchers, which developed a good and open research team together with the clinicians, and were setting the main point in clinical research and the results of institutional treatment. When the department in late 70ties developed a crisis, caused by new obligations to admit immediately all psychotic and suicidal patients as emergency cases from the catchment area in the city, the number of psychotic inpatients increased rapidly, and the more neurotic patients were treated in the out patient clinics. Many of the nurses working in the acute unit developed signs of burn-out syndrome, their organization of the therapeutic community did not work any longer. The research which included patients, staff and the ward atmosphere, showed clearly that the milieu and the groups were now harmful for many of the psychotic patients.

In 1981 the whole treatment program was then radically changed to an individually oriented therapeutic milieu, where the psychotic patients were separated from the more acting-out borderline patients, who got a special organized, group oriented day unit. Now, the nurses now were more caretaking of the psychotic patients and took more responsibility and leadership. After one and two years the researchers found that the ward atmosphere showed reduced aggression and was warmer, the patients said they had a much better ward milieu, and the burn-out syndrome in the staff was resolved. These results were published in a book and in several Scandinavian and international journals, and resulted in a couple of doctorate degrees.

The engagement and enthusiasm of Jarl Jørstad in promoting psychodynamic understanding, modified psychotherapy and optimal milieu therapy for psychotic patients, influenced many professional workers in psychiatry, both in Norway, Sweden and Denmark. He was asked to give many seminars in these countries, and delegations came from them to learn from the experiences at Dikemark and Ullevål hospitals. He was also asked to be a

consultant for institutions in crisis, which was a result of his interest and study of irrational group processes which influence teamwork and leadership in all organizations (Tavistock), and which gave him many tasks in Scandinavian countries and in Switzerland.

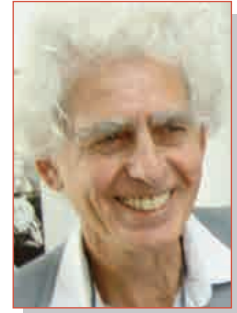
Together with a large group of young psychiatrists he also contributed to a radical change of the teaching and training of psychiatric residents in the 1970ties in Norway. In spite of resistance from most of the professors in psychiatry, they managed to introduce obligatory supervision in the therapist-patient relationship, and the basic principles of psychodynamic psychotherapy, once a week in one year, later extended to two years. As leader of the psychotherapy committee in Norwegian Psychiatric Association he also formulated the qualifications of the supervisors: they should be experienced psychotherapists, and should have had their own personal psychotherapy or psychoanalysis. Later special courses in supervision were also developed.

In his books and many papers he focused more and more on the early mother-child relationship as background for vulnerability in later life, the unconscious forces in human mind, and the transference/countertransference interaction in therapeutic relationships of severely disturbed patients. His popular psychiatric books were published in a couple of editions both in Norway, Sweden and Denmark, the first also in Poland, and the last in UK.

From 1990 he has still had his private psychotherapeutic and psychoanalytic practice in his home in Sandvika outside Oslo, but now only a few hours a week.

Svein Haugsjerd

Julian Leff



Julian Leff must be one of the best known of the few contemporary psychiatrists who have made major contributions to the *psychological* therapies of psychosis that have gained acceptance within psychiatry. Though there are plenty of psychiatrists well known within the psychological therapies field, few from the latter territory have become household names in the wider psychiatric field.

Julian Leff has researched in many areas during his thirty eight years with the Medical Research Council, during which time he has always held clinical appointments. He is surely best known for his now widely replicated research demonstrating the possibility of substantially reducing relapse and readmission rates in patients with schizophrenia by working with the families to reduce 'Expressed Emotion' and excessive contact. Indeed, his 1982 paper describing this work has become a classic, with over 500 citations in the world literature. The research work also demonstrated the synergic effect of combining psychosocial and pharmacological interventions.

In a psychological therapies field often beset by theoretical partisanship, Julian Leff has staunchly maintained his role as a social scientist and much of his work is rigorously empirical. He has gone on to demonstrate that expressed emotion is not a particular characteristic of families with psychosis and through research refuted the specificity of communication deviance in families that was gaining hold in the 1970s and 1980s, a matter that remains a source of scientific controversy. He has therefore played an invaluable part in retaining the focus on the importance of aspects of the family in psychosis. He has done this without re-evoking the complex problem of family attribution which has led to many professionals abandoning involvement with families who have considerable needs for help both in their own right and in the specific professional assistance they often need to provide domestic environments that will be maximally facilitating to the recovery of their relative.

It remains a matter of international concern that, in spite of the long acceptance of the concepts and the research evidence, few psychiatrists learn how to engage families to the latter's satisfaction when they have a

member prone to psychosis, let alone apply the specific interventions that Leff and his colleagues demonstrated to be effective more than three decades ago now. This is strong evidence that psychiatrists are quite selective in the evidence they choose to implement.

Julian Leff has played an important role in supporting the development of the roles of community psychiatric nurses through the many psycho-social training programmes now present in many parts of the UK.

It may be interesting for ISPS members to know of some of his wider contributions in social psychiatry. Some of Leff's early research was on the effect of sensory deprivation in the production of hallucinations in normal persons. The role of culture in psychiatric disorders has always been prominent in his research interests. One expression of this was his contribution to the work clarifying different diagnostic practices towards the psychoses on the two sides of the Atlantic. His work with Professor John Wing and others in standardising assessment interviews and rating scales has made international research work much more possible and relevant. He also conducted cross-cultural studies of expressed emotion, demonstrating the general reliability of his key findings of the association between high expressed emotion and psychosis relapse rates in the different cultures. There were also important studies highlighting the important fact that mental health settings can contain professionals who themselves create a deleteriously high expressed emotion atmosphere.

His research work on cultural commonalities and differences has involved him in projects in countries far and wide in the world of which a few are Barbados and Trinidad (in the West Indies), Aarhus (Denmark) Chandigarh, (N. India), Chengdu, (China). It goes without saying that the importance and interest in his expressed emotion work has led to invitations to speak all around the world.

In more recent years, the research focus has been on the well being of long stay patients when discharged thoughtfully into the community following the closure of the hospitals that had been their homes for decades, demonstrating the possibility of successful rehabilitation and relocation.

Another interesting and important research was into severe depression in one partner in a couple relationship, comparing psychological treatments with the best of medication management and showing the superiority of the former.

One could almost write a book just reviewing Julian Leff's published life work as this amounts to more than ten books authored, co-authored or edited, some hundred or more chapters and more than 150 research or review articles, nearly all in the world's prominent journals.

Julian Leff's family background included medical members of which his father was one. Because of the war, his grandfather was an especially important figure at home in a small Buckinghamshire village. Buckinghamshire is of course well known for another pioneering schizophrenia study by Ian Falloon and others. Julian's empirical approach has withstood the fact that he is married to a prominent UK psychoanalyst!

When Murray Jackson (another ISPS Life Member) retired from the Maudsley in 1987, Julian Leff took over the in patient unit that Murray had been the consultant to.

Professor Leff has now substantially retired and spends a considerable amount of time developing his longstanding skills with the piano where - to quote *"I delight in playing with other instrumentalists and singers, and feel that achieving unison in a small chamber group is akin to working skilfully with a family. As his tutor says, 'the most important thing is to listen, listen, listen!'"*

Those of us who have encountered Julian at ISPS conferences and elsewhere will probably have similar images of him as a quiet, friendly modest man in social settings, but an eloquent and powerful communicator and teacher when lecturing. His international contribution to the social and psychological well being of those vulnerable to psychosis and their families has been immense and we have little doubt that this influence will continue for the decades to come as the scientific, profession and lay public are increasingly convinced of the relevance of the importance of the interplay of the psychological and social with biology in psychosis. We are delighted that Professor Julian Leff has accepted Honorary Life Membership of ISPS.

Brian Martindale

Theodore Lidz



Theodore Lidz, the Sterling Professor Emeritus of Psychiatry at Yale, lived to be 90 years old, dying on February 16, 2001. He lives on through his book, *The Person, His and Her Development Throughout the Life Cycle* which probably can be found on the bookshelves of essentially all mental health professionals who trained during the decade after its publication in 1976; it is still in print. He dedicated his career to understanding the interpersonal causes of schizophrenia, focusing on family, community and cultural factors, and the details of the person's life history. He was convinced of the continuity between health and psychosis.

Ted Lidz was born in New York City and grew up on Long Island. He received his B.A. and M.D. from Columbia University. He completed two years of medical internship at the Yale-New Haven Hospital and then became an assistant in Neurology at National Hospital, Queen's Square in London. His psychiatric residency, at the Johns Hopkins Henry Phipps Clinic, was under the leadership of Adolf Meyer. There, he met his wife, Dr Ruth Maria Wilmanns, who had fled Germany in 1934 and arrived at Hopkins in 1937. They married in 1939. She died in 1995.

Lidz enlisted in the Army in January, 1942 and served in New Zealand, Fiji and Burma. His Fiji tour left him caring for hundreds of psychiatric casualties from Guadalcanal, he the only psychiatrist. Years later, he and Ruth returned there to study the culture, and the book, *Oedipus in the Stone age: A Psychoanalytic Study of Masculinization in Papua New Guinea*, grew from their studies.

On his return to Hopkins in 1946, he served as the psychiatric liaison clinician and began research on psychosomatic conditions. He and Ruth trained in psychoanalysis in the Washington-Baltimore Psychoanalytic Institute, learning from Harry Stack Sullivan and Frieda Fromm-Reichmann. They studied the psychiatric difficulties of parents of children hospitalized with schizophrenia, and this launched Lidz's later extensive studies.

The Lidzes moved to Yale in 1951 when Ted became professor and chief of clinical services. Along with Stephen Fleck and others, he launched a long-

term study comparing 17 schizophrenic patients and their families with 17 non-schizophrenic hospitalized patients and their families. The book he co-authored with Stephen Fleck and Alice Cornelison, *Schizophrenia and the Family*, 1965, International Universities Press. He was a fellow at the Center for Advanced Studies in the Behavioral Sciences at Stanford, a great honor and opportunity.

Lidz was a lifelong principal fighter against biological reductionism and the view that schizophrenia is incurable, and for the benefits of psychotherapy. He formally retired in 1978, but continued treating patients. He yearned to write one more book, refuting biological reductionism.

His fierce loyalty is reflected in a telling exchange of letters with Gore Vidal in the *New York Review of Books* published on June 13, 1985, "Caring for the Bird."

To the Editors:

"I was not enlightened by Gore Vidal's review of the two books about Tennessee Williams [*NYR*, June 13], and found the review distasteful, if not repugnant. However, the question of what is suitable for publication is a matter for the editors of the *Review*. I write because of what he has to say about Dr. Lawrence Kubie. Dr. Kubie is dead and cannot defend himself and he was a friend and colleague of mine.

I do not know what transpired in Dr. Kubie's therapeutic work with Tennessee Williams as Dr. Kubie kept such matters to himself. However, Dr. Kubie was a leading psychoanalyst and psychoanalysts do not *order* patients to do anything and it seems highly doubtful to me that Dr. Kubie "ordered him to give up both writing and sex so that he could be transformed into a good team player." Also in the light of Tennessee Williams's dismal last years, why does Vidal write, "happily the Bird's anarchy triumphed over the analyst." Throughout his article Vidal quotes a number of instances in which Williams distorted or altered the truth and certainly there is ample reason not to accept Williams's version of what went on in his analysis.

Dr. Kubie did not take down his shingle and retire from shrinkage. When he left his practice in New York, he did so to accept the position as Director of Psychotherapy at the Sheppard and Enoch Pratt Hospital in Towson, Maryland, a very important position in one of the country's major psychotherapeutic institutions.

I did not agree and still do not agree with Dr. Kubie's concepts about creativity, but I find Vidal's snide comments about a man who devoted his life to the care of patients and the promotion of mental health highly offensive." Theodore Lidz, M.D.; Yale University; New Haven, Connecticut

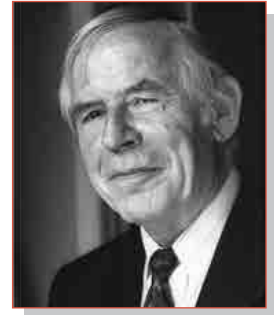
Gore Vidal emeritus replies: "I am saddened that Dr. Lidz was not "enlightened" by my review, but not all darkness is penetrable, particularly that generated by, if I may say so, his own peculiar calling. Perhaps "ordered" was too strong a verb. Certainly Dr. Kubie gently hinted. ... Is that better? God knows Tennessee dramatized his own life; and he certainly got things wrong, but he was never a liar. As for Dr. Kubie, I draw the readers of this review to his appearance, under the name Dr. Sanford Kubie, in a forthcoming novel, *October Blood* by Francine du Plessix Gray. Here they will see Kubie as many people at the time did—a slick bit of goods on the make among the rich, the famous, the gullible.

Lidz is survived by three sons, eight grandchildren and five great-grandchildren.

I am grateful to the Yale Bulletin and Calendar for posting the March 2, 2001 Volume 29, Number 21 issue on the internet, which provided most of the information in this summary.

Ann-Louise S. Silver

Christian Müller



He was born in 1921 in Münsingen near Berne/Switzerland where his father, Prof. Max Müller, was medical director of a great psychiatric hospital. His grandfather, too, was a psychiatrist. Christian Müller achieved his studies of medicine in Berne in 1946 and habilitated in psychiatry and psychotherapy under Manfred Bleuler in Zurich in 1957. From 1960 through 1982, he was ordinary professor of psychiatry and director of the psychiatric university clinic of Cery/Lausanne, Switzerland.

On the base of a classical medical, psychopathological and psychoanalytic-psychotherapeutic education, he developed a deep interest in the long-term dynamics of the main mental illnesses, especially schizophrenia. Already since the fifties of the last century, he was an engaged reformer of institutional psychiatry in Switzerland and one of the world's first pioneers of a psychoanalytically oriented psychotherapy of schizophrenia. In 1956, he founded with Gaetano Benedetti from Basel/Switzerland an international working group on this topic which organised periodical international symposia on the psychotherapy of schizophrenia first in Zurich and Lausanne, and then abroad. This group marked the very beginnings of the later International Society for Psychotherapy of Schizophrenia.

Christian Müller's main research focus was on long-term evolution of mental illnesses until old age. His catamnestic long-term investigations on all main psychiatric illnesses which he inaugurated in the sixties under the name "The Lausanne Enquête" are among the longest in the world. After his retirement in 1982, he mainly worked on historical psychiatric themes. He has published a great number of scientific papers and books, covering different fields of psychiatry. As member of several national and international scientific societies, he was also influential in reforming psychiatric care structures and promoting community-related networks for rehabilitation. Furthermore, he was as a core-member of the editor-board of "Psychiatrie der Gegenwart", the leading German psychiatric encyclopaedia. As co-founder of an European working group for geriatric psychiatry, he was also one of the earliest European psychiatrists who developed a special interest in old age psychiatry on which he published the first textbook. He earned several international scientific

awards and was promoted Doctor honoris causa of the University of Heidelberg in 1980. On the international as well as on the national level, where he is looked at as “the grand old man” of Swiss psychiatry, he is highly estimated for both his professional and his human qualities. He currently lives in Berne/Switzerland where he continues to be an active psychotherapist and psychoanalyst.

Honors: Hermann-Simon Award (Germany) 1971, Theodor Nägeli Award (Switzerland) 1976, Member of the Akademie Leopoldina (Germany)

Main books:

Mikropsie und Makropsie (Karger, Basel 1956)

Über das Senium der Schizophrenen (Karger, Basel 1967)

Alterspsychiatrie (Thieme, Stuttgart 1967) / Abrégé de psychogériatrie (Masson, Paris 1981)

Lexikon der Psychiatrie (Springer, Berlin 1973)

(with L. Ciompi as first author): Lebensweg und Alter der Schizophrenen (Springer, Berlin 1976)

Les maladies psychiques et leur évolution (Huber, Berne 1981)

Les institutions psychiatriques (Springer, Berlin 1982)

Études sur la psychothérapie des psychoses (Privat, Toulouse 1982)

Die Gedanken werden handgreiflich (Springer, Berlin 1992)

Vom Tollhaus zum Psychozentrum (Pressler, Hürtgenwald 1993) / De l'asile au centre psychosocial (Payot, Lausanne 1997)

Wer hat die Geisteskranken von den Ketten befreit? (Psychiatrieverlag, Bonn 1998)

Paul Dubois (1848-1918) (Schwabe, Basel 2001)

Rorschach, Briefwechsel (Huber, Bern 2004)

Luc Ciompi

Barbro Sandin



“With all my might I wanted to fight for the restoration and renewal of at least one of these forgotten persons.” This is how Barbro Sandin describes her first meeting with schizophrenic patients at Säter Mental Hospital in January 1973. Barbro was at that time 40 years old, a former housewife and the mother of three children. She was a newly educated social worker, but still not a trained psychotherapist. She was deeply familiar with philosophy and literature and – since she was brought up in a religious environment – with the language of the Bible, which she used in her own independent way.

The result of this first meeting was a powerful and devoted commitment – continuing to date.

Barbro’s report on the work with her first patient in The Swedish Medical Journal 1975 was a light in the dark for many of us who could not see how we would be able to help psychotic patients. However, major part of the Swedish psychiatric profession was sceptical and critical – for many years even resistant and hostile. As a psychologist, I soon got in contact with Barbro and had the advantage of being supervised by her.

I would like to highlight what I believe characterise her long-lasting work.

Shortly, Barbro became a source of inspiration and she set the tone within psychotherapy of psychoses, not only in Sweden but in Scandinavia as a whole. She contributed to drawing attention to the conditions of the patients and to reducing the taboos and fears that surround schizophrenia. The patients themselves, and not least their relatives, got new hope and the strength to forward new demands on public healthcare. However, this was not well received everywhere.

The first patient who Barbro worked with was Elgard Johnsson. He describes his time at the hospital, his meeting with Barbro and his path towards health in the book “Tokfursten” (“Prince Madness”), published in 1986. The book by Barbro, “Den zebrarandiga pudelkärnan” (“The zebra-

striped nucleus of the poodle”), was published the same year. In the book she gathers her experiences and thoughts about schizophrenia and psychotherapy from the first ten years of her work. The book formed the basis of her doctor’s thesis, which she defended in Tromsø in 1986. A few lines from the summary of the opponents (S. Haugsgjerd and V. Rosvaer) are illuminating: “Her theory about human experience is fundamentally applicable and may enrich several more specific subject-oriented theories.” “She moves the concepts of transference–countertransference from the interpretational position of psychoanalysis towards the active and engaged position to fellow humans in existential philosophy – a shift from a neutral to a loving understanding.”

The importance of Barbro is of course due to the encouraging good results that she and her team achieved in their work with schizophrenic persons. Barbro also has a unique and engaging ability to share her experiences. In her lectures she always departs from case-studies. Her starting point is the existential perspective – the genuine meeting with the patient, keeping in contact with the common human conditions of good and evil, life and death, loneliness and sense of community. With her common language Barbro also creates a “meeting room” when she delivers lectures or talks, with sincerity and humor in harmony. She helps us to “hear” the patient’s actual situation. Over the years she has also convincingly shared her experiences from a large number of patients’ radical journeys towards health and freedom from psychosis.

Barbro has always emphasized that psychotherapy with psychotic patients is a teamwork. What became known as the “Sandin model” requires, that around the patient there is a group of staff, who work continuously and reliably for many years in enduring everyday contact, with outpatients as well as with inpatients. The treatment is built on a long-term perspective with a focus on every patient’s unique personality and circumstances. Barbro holds that the person who suffers from schizophrenia withdraws from life and development in his attempt to get away from destructive anxiety. The patient thereby loses the communication inherent in a relation, which is precisely what he needs to be able to develop. He suffers from not being able to exist, he needs above all our co-existence. The patient must obtain faith in life and in its possibilities from his human environment until faith in life becomes his own solid experience. Consequently, the human relations in the treatment milieu are of crucial importance for the ability of the patient to develop his own confident self. Barbro often refers to Martin Buber: The Self is created in the meeting with Thou.

The supervision by Barbro on the basis of these premises was innovative in the late seventies. Every member of the team participated and no one prevented the patient himself from dropping in. Old structures were thus broken and human resources, not least those of the patients themselves, were used. Everyone became aware of one's own importance, maybe as a "life line" to which the patient chose to attach himself until his contacts could safely be widened to others – or as a "container" of those feelings that the patient was not yet able to contain himself. The respect for the patient increased while the respect for the sickness or madness decreased. A non-sentimental, open and prestigeless atmosphere developed, where humour and enjoying life became resources of great value. Since everyone during an extended period of time got to know the patient as a person and his life history, as it became visible in the therapy work, everyone involved also came to understand the former "patterns of sickness." Many were those patients who thereby got radically changed opportunities in life.

Barbro's far-reaching work as a lecturer and supervisor has been important not only for the patients, but it also changed many people's view of schizophrenia and its treatment – even their view of their own lives. Psychotherapeutic work with psychoses is overwhelming and enriching for everyone involved.

In 1987 Barbro received a donation of one million SEK from a private person. She then left public psychiatry and was, together with her co-workers who all joined her, able to start the Walla Foundation Clinic in Ludvika – a beautiful and "homelike" treatment environment, which is beneficial for those who need environmental confirmation that they are appreciated and valuable. At Walla the work continued with patients, various educational programmes was organized and an annual conference on psychotherapy of psychoses was held. We are hundreds of participants who over the years have gotten the opportunity to listen to and be inspired by prominent international lecturers with comprehensive experience from treatment of psychoses. We acquired increased knowledge, a broader perspective on our not very glamorous daily duties and the joy in our work was reinforced. We will remember the jolly conference parties for many years.

In her work and in her view on schizophrenia and treatment, Barbro separates the existential aspects of human life from other fields of knowledge. I have understood her main point in her work with patients in the following way: we must seek to confirm their courage to live and the creative

power inherent in all of us, but which the patient suffering from schizophrenia lacks a firm experience from. The originally “created illusion of paradise” must be able to grow into the world, with sufficient security, in order to maintain faith in life and the creative ability.

When it comes to psychological and psychotherapeutic influences, Erich Fromm, Donald Winnicott and Jean Piaget among others are important for Barbro’s thinking. Personally, I am pleased to note that modern research on infants, for instance by Daniel Stern, confirms many of the thoughts developed by Barbro. This applies, for example, to her ideas about the needs of the infant in its growing into an individual and to what is needed in psychotherapy of psychoses in order to bring about a lasting maturity.

Walla still works in the spirit of the “Sandin model” and although Barbro retired in 1993 and later moved to Gothenburg, she continues to supervise, for example at Walla.

In 1993 “Crossing the borders” was published, a book on psychotherapy of schizophrenia, to which Barbro contributed. Together with Lisbeth Palmgren, Barbro has written the book “Galenskap som risk och möjlighet”, (“Madness as a risk and possibility”) in 2000, in which they reflect on authors with mental suffering

The writings of Barbro are unfortunately mainly available in Swedish only. Barbro Sandin will however be represented with an essay in the book that the ISPS intends to publish in 2007.

Kia Sjöström

Harold F. Searles



Harold Searles, now living in retirement with his wife and former nurse Sylvia in Davis, California, is 87 years old. He had loved California since his Army years there, and had kept his California license updated, although he has not practiced there during this past decade. Born and raised in Hancock, New York, a bucolic little town nestled in the Catskill Mountains and on the banks of the Delaware River, Searles came very naturally to write his first monograph on *The Nonhuman Environment: In Normal Development and in Schizophrenia*. However, family life was idealized but was filled with complicated and chronic anxieties and depression, as Searles describes in his dialogue with Robert Langs, *Intrapsychic and Interpersonal Dimensions of Treatment*.

Searles's great contribution to the mental health field is his personal honesty – his openness to his responses to the other person, and his ability to articulate these responses. In his writings and in his many demonstration interviews of patients (which he has said was his favorite clinical activity after leaving the Lodge), he set a very high standard for all of us. The boundary between the pre-conscious and the conscious moves back, when we have the courage to face ourselves more fully. When we hide behind a professional mask of warm-hearted dedication, aiming at being such good and empathic people, we diminish our access to our patients, and find one false self in pseudo-interaction with another person who then plays some part in an unreal drama: "...a healthy hopefulness needs to be distinguished clearly from an essentially manic repression of feelings of loss and despair." (Searles, 1979, p. 483) As Searles moves from clinical vignettes to theoretical explication, the reader often has the feeling, "I almost thought that, myself," or, uncannily, "He knows me better than I know myself."

Thus, Searles's writings should be studied by each of us, aiming at developing our clinical skills and emotional capacities in general. One's countertransference responses gradually become one's strongest therapeutic tools. He says, after detailing the grinding isolation he experienced in years of work with a hebephrenic man, "To my enormous relief I realized that I could now be related to him without having either to kill him or fuck him." (Searles, 1979, p. 431) Like reading the works of Ferenczi

and Winnicott, one senses his presence as a gifted supervisor of one's ongoing clinical struggles; he is thus a perpetual vibrant supervisor and therapist. A prolific writer, he gathered his many papers into books which have remained in continual print. The topics include many aspects of psychoanalytically oriented work with patients suffering from schizophrenia, from manic-depressive illness and from the borderline condition. While his books sold excellently, they do not turn up often in used book stores; their owners cherish them. And when psychiatrists get together, recalling their residency training, they very often recall Searles's "one-shot interviews" which so often revealed pivotal events in the interviewees lives, which their therapists had known nothing of, and which evoked volcanic emotional outpourings, which the therapists had thought were beyond the capabilities of their seemingly frozen and hopeless patients.

Searles obtained his B.A. at Cornell University, in 1940, and his M.D. at Harvard Medical School in 1943. He began his residency training at the New York Hospital and then served as a Captain in the Army's medical corps, serving at the Washington DC Veterans Administration Mental Hygiene Clinic. He began his psychoanalytic training while there, at the Washington Psychoanalytic Institute. His analyst was Ernest Hadley. Searles became a training and supervising analyst there and served as President of its Society from 1969 to 1971. He was on the medical staff of the world-famous Chestnut Lodge Hospital from 1952 until 1964, working closely with Frieda Fromm-Reichmann. His office was in the Frieda Fromm-Reichmann Cottage after her death in 1956. Colleagues at the Lodge included Marvin Adland, Dexter Bullard, Sr., Donald Burnham, John Cameron, Beatriz Foster, John Fort, Robert Gibson, John Kafka, Ping-Nie Pao, Alberta Szalita, Otto Will and many others, all sharing their ideas, friendships and competitiveness.

Searles served as a Clinical Professor of Psychiatry at the Georgetown University School of Medicine, and contributed significantly to the residency training program at the Sheppard and Enoch Pratt Hospital in Towson, Maryland, and the Columbia University residency program in New York City. Additionally, he was a consultant at the National Institute of Mental Health, working on the project studying the Genain quadruplets.

In each issue of the ISPS-US Newsletter, edited by Brian Koehler, PhD, this quotation from Searles is in the banner: "Innate among man's most powerful strivings toward his fellow men...is an essentially psychotherapeutic striving." (Searles, 1979, p. 459) "More and more during the past several

years, I have come at last to see something of how frequently the analyst has cause to feel gratitude toward the patient.” (Searles, 1979, p. 437)

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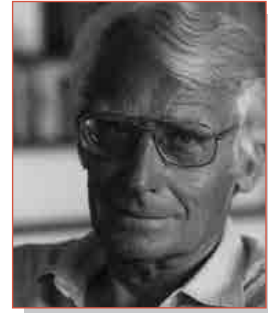
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Ann-Louise S. Silver

Helm Stierlin



Helm Stierlin was born in 1926 in Mannheim. He lost his father rather early. Whereas his brother became an engineer (living in Malaysia for many years), he himself was caught between philosophy and medicine. He studied both subjects in Heidelberg, Freiburg and Zurich. In Heidelberg his academic teachers were Karl Jaspers, Alfred Leber, Alexander Mitscherlich and Victor von Weizsäcker. Jaspers became his “Doctorvater” for his philosophical dissertation.

After finishing medical school, in 1953 he went to Munich. He was disappointed by German post-war psychiatry, as it was practiced at the time in Munich’s “Universitätsnervenklinik”. Through the literature of Harry Stack Sullivan’s writings he became curious about modern psychiatry and earned a scholarship for the Sheppard-Enoch Pratt Hospital in Towson, Maryland near Baltimore. From there he changed to Chestnut Lodge, the legendary center for psychoanalytic treatment of psychosis. Even though Frieda Fromm-Reichmann had already died in 1957, he met Otto Will, Hilde Bruch and others. At that time family therapy began to evolve rapidly throughout the United States. Soon Stierlin came into contact with Gregory Bateson (who had also worked at Chestnut Lodge before), Ted Lidz, Murray Bowen, Nathan Ackerman, Lyman Wynne, and Ivan Boszormenyi-Nagy. This opened the family perspective for the treatment of schizophrenia and was from then on a decisive turning point in Helm Stierlin’s until then psychoanalytically oriented professional life. After the short interlude in Europe from 1963 to 1965 (Bellevue Sanatorium, Bellevue-Kreuzlingen, Switzerland) and two shorter study periods in New Zealand and Australia, Helm Stierlin returned to the United States and became a member of the National Institute of Mental Health, where he worked together with Lyman Wynne and Margaret Singer, famous developers of family psychiatry. As head of the adolescent unit, Stierlin worked on young runaways, and his first well-regarded book was on separating parents and adolescence.

A new period began after Walter Bräutigam brought Helm Stierlin back to Heidelberg to the Department of Psychosomatic Medicine, where Stierlin became director of the Department of Psychoanalytic Research and Family

Therapy in 1974. From then on his theoretical and clinical work rapidly expanded. The Heidelberg concept grew, especially in cooperation with the Milan group (Mara Selvini Parazzoli, Luigi Boscolo and Gianfranco Cecchin). Stierlin also dealt with psychosomatic issues from then on and with family dynamics and treatment of severe physical illness (i.e. cancer patients).

Stierlin rapidly became a fixed point in Germany's professional and cultural scenery. He was founder of the famous journal "Familiendynamik" and author of thirteen books translated into twelve languages, e.g., *Separating Parents and Adolescents*, *Conflict and Reconciliation*, *Psychoanalysis and Family Therapy*, *The First Interview with the Family*, *Unlocking the Family Door*, *Demokratisierung der Psychiatrie*. The number of his scientific articles is approaching 300.

Helm Stierlin is also a family man at home. His wife, Satuila Stierlin, also a recognized clinician, teacher and family therapist, and his daughters, Larissa and Saskia, build the most important frame in his life.

Today almost 80 years old, Helm Stierlin is still busy in teaching, travelling and writing. He is a critical reviewer of development, not only in family therapy, but also in our society in general. Coming from a psychotherapy of schizophrenia, which heavily influenced clinical and theoretical thinking, he has expanded to become one of the prominent thinkers and workers in today's fast-expanding world of psychotherapy.

Michael Wirsching

John S. Strauss



John Strauss is a warm and gentle man and a scholar, a prolific psychiatrist researching persons suffering from severe mental disorders. His over 200 scientific papers address issues of diagnosis, course of disorder, and the processes of improvement. He emphasizes the role of the person with mental disorder as a person in the struggle to recover, and understanding in depth the subjective experiences of people with severe disorder. These experiences provide crucial data for understanding and treating the basic processes involved in disorder and recovery.

John Strauss represents the best in phenomenological research into severe mental disorders. He does not turn his research subjects into the *objects* of study, but tries unstintingly to feel his way into their way of being, to imagine his own struggle to regain sanity, to imagine the moment-to-moment pain caused by these alienating afflictions. Thus he sets an example not only as a prolific researcher but as a strong therapist. Listening to his talks (he was the keynoter for the ISPS-US annual meeting in Philadelphia in 2004), we felt we had known him for a long time, a valued friend for years. He let us into his thinking and feeling. He described the time when at a large conference he had role-played a patient and found himself utterly deflated and sullen, unable to continue talking with the interviewer. The interviewer had asked him about work, and John started telling about his new job at McDonalds. The interviewer wasn't interested in the details but moved on to the next question. It took a while for John to realize that he became silent *because* he felt hurt and angry. The few patients in the audience all responded that they, too, had had such experiences. As the discussion evolved, John felt that he and the "other" patients were allied against the defensive professionals, and that there never was resolution.

John was born in Cleveland, Ohio in 1932. He earned his B.A. degree with high honors at Swarthmore College, majoring in psychology (Swarthmore's t-shirts read "A 'B' here would be an 'A' anywhere else.") He earned his M.D. at Yale and then was a special student with Jean Piaget in Geneva, Switzerland. He then studied community psychiatry at the Washington School of Psychiatry. He was a resident in medicine and then in psychiatry at the McLean Hospital

and Beth Israel Hospital in Boston, then worked at the National Institute of Mental Health from 1964 to 1972. After a stint at the University of Rochester, he settled in at Yale, where he has worked since 1977. Since 1985, he has served as Director of the Center for Studies of Prolonged Psychiatric Disorder, Connecticut Mental Health Center, New Haven, CT.

He was a Collaborating Investigator in the World Health Organization's historic comparative research in schizophrenia, and has served on many scientific councils including the Veterans Administration on Rehabilitation Research in Mental Health, the Scientific Council of the National Alliance for Research on Schizophrenia and Depression (NARSAD) and the Society for Life History Research in Psychopathology. He has received many grants from NIMH and other granting agencies, mostly on schizophrenia, including the processes of improvement. He has never lost sight of the person struggling with the disorder.

John Strauss is worldly, living part of each year in France, traveling often to Scandinavia, his works translated into French, German, Norwegian and Japanese. He says he has combined French phenomenology with American pragmatism in his views on effective research into schizophrenia. He stresses that occupational rehabilitation is not an ancillary part of treatment but is a central part of the recovery process. Patients often tell him, "When I work, I don't hear voices." As people recover from psychosis, they talk about reintegration and the sense of finding out who they are; they talk about resolving conflicts about goals. Relationships are central to the recovery process, not just relationships with professionals, but with their fellow humans in general. He chides the profession, reminding us that recovering patients routinely say how rare it is to find a doctor who took them seriously. He still is working over a patient's challenge to him: "Why don't you ever ask me what I do to help myself?" He says, "This is a very heterogeneous disease with a very heterogeneous outcome. There's been a tendency to dehumanize and depersonalize schizophrenics, but that's bad science, and bad for everyone involved. I've interviewed many patients, and I can tell you that we're talking here about people with goals who are struggling to make sense of life. I don't know any basket cases."

For over a decade, John has hosted writing groups in various countries, supporting people writing about their work with patients. His one strict rule is that negative remarks are forbidden; he finds that the problems in the

writing drop out by themselves. This would be a great rule by which all therapists of psychosis should abide.

Ann-Louise S. Silver

Endre Ugelstad



Endre Ugelstad was well known for his work to promote psychotherapy for persons with psychoses, and especially for encouraging long term supportive psychotherapeutic approaches. He inspired many by his skilled supervision of staff to do such dedicated work. He had psychoanalytic training, but he believed that good therapeutic work could be carried out by all clinicians who had the capacities to form relationships with the psychotically vulnerable and that this in itself could lead to considerable improvements for the patients.

He received his MD in medicine at the University of Oslo in 1948 and worked as a resident in psychiatry at Gaustad Hospital and Ullevål Hospital in Oslo from 1950 to 1956. He then worked a few years in private practice. Later he worked for many years as a psychotherapy consultant at Gaustad Hospital, where he was one of the first in Norway to give group psychotherapy to persons with psychosis. He was a member of the Norwegian Psychiatric Association and of the Norwegian Psychoanalytic Association.

Endre was one of the founders of the Institute of Psychotherapy in Oslo in 1962. He took active part in the development of the institute and later became an honorary member. The Institute was established to make training in psychodynamic psychotherapy more available and to make psychotherapy more available for patients with more severe disorders. The Institute has continued to develop this vision and is organising training in psychotherapy throughout the country.

Even though Endre did not pursue an academic career and never got a high academic degree, he saw the value and importance of research and took initiatives to studies on psychosocial treatments of psychoses. Within the framework of a comparative study he and his co-workers at Gaustad implemented alternative treatments for long term patients with chronic severe mental illness. He later presented this at the 5th International Symposium in the Psychotherapy of Schizophrenia held in Oslo in 1975, and in 1977 he received the King's Gold Medal for his thesis on "Psychotic Long Term Patients in Psychiatric Hospitals." He became increasingly aware of

the need to do research also in order to get politically strong arguments in claiming the need for adequate resources for therapy.

Together with other Nordic colleagues Endre focused on interventions for first time psychoses in the NIPS study (Nordic Investigation on Psychotherapy of Schizophrenia) carried out in the 1980s and 1990s. Their book "Early treatment for schizophrenic patients" was published in 1994. This work also led to a Nordic network for research on early treatment of psychosis.

In 1990, almost thirty years after being a co-founder of the Institute for Psychotherapy, Endre was one of the co-founders of SEPREP - Centre for Psychotherapy and Psychosocial Rehabilitation of Psychoses, which is a non-commercial foundation and a network of clinicians and researchers promoting psychological treatment of psychoses in Norway. Endre was engaged in all the three types of activities in SEPREP: training therapists, disseminating information on psychoses and treatments and stimulating research. He was involved in starting a two year seminar on psychotherapy for psychoses and in the early phase of a national multidisciplinary training program for treatment of psychoses. The bulletin Dialog was started for communication between people interested in psychotherapy and psychosocial rehabilitation of psychoses. A couple of years after Endre died the new society ISPS made an agreement with SEPREP to get secretarial services from SEPREP.

Endre attended some of the earlier symposia and served on the organising committee of the 5th International Symposium on the Psychotherapy of Schizophrenia in Oslo 1975. He was one of the editors of the book published in 1976 with proceedings from the symposium. At the ISPS 1994 in Washington Endre took the initiative to form the ISPS network and became the chairman of the board. He was one of the driving forces to develop the ISPS network into an international society, and he was arguing that ISPS should develop a broader range of activities and promote a wider range of psychosocial treatments. He also started to publish the ISPS newsletter for the network. At that time he knew of his cancer. During the next years with preparation of the ISPS 1997 in London and of the ISPS as an international society, he gradually had to withdraw from the ISPS board.

Endre met his first wife Signe when they both worked at a psychiatric hospital before he started his education to become a physician, and in their

marriage for twenty years they had three children. His second wife Harriet also worked in the mental health services, and they shared the interest in the work for persons with psychoses. They had two children.

Endre died quietly at 76 years old on September 6, 1996 after four years of cancer. During the whole period of the illness he was open about the development to his family and friends, continuing to be very much present in life and including death as a natural part of it.

Endre Ugelstad made important contributions to psychotherapy and psychosocial rehabilitation for psychoses in Norway, the Nordic countries and internationally. All of us, who continue the work in ISPS and the other organisations that were initiated by him and other co-founders, are grateful to him and remember him as an inspiring example and a good friend. But also many therapist and patients who did not know Endre have been positively influenced by his work through the impact he made on those who met him and worked with him.

Torleif Ruud

Lyman C. Wynne



In 1923, Lyman C. Wynne was born into an impoverished but intellectual Danish family in a Southern Minnesota village. A farmer and businessman, Lyman's father supported the family on \$350 per year and crops, though he discussed Spinoza and Kant with his children. Lyman's mother was bedridden with uterine cancer for four years. At age 11, while his mother was dying, Lyman decided to become a medical researcher. At age 12, he was sent to live with an aunt and uncle in Duluth and from there obtained a full scholarship to Harvard. During the WWII, Lyman was assigned by the army to attend Harvard Medical School. In 1945, with the war ending, Lyman became a protégé of Erich Lindemann. That experience changed Lyman's career path from cancer researcher to psychiatrist and ultimately, family therapist. Lyman's first participation in psychotherapy was with Lindemann, not meeting with individual patients but with what Lindemann called the "social orbits" of highly disorganized families that included psychotic and psychosomatic members. During that period, Lindemann was publishing and discussing his pioneering studies of normal and unresolved grief.

After a medical internship at the Peter Bent Brigham Hospital, Lyman postponed psychiatric residency to return to Harvard for research training in the newly formed interdisciplinary Department of Social Relations. With Dick Solomon, he began research on the role of the autonomic nervous system in traumatic avoidance learning in dogs; it was a biopsychosocial study. He also participated in small seminars with Talcott Parsons who was writing his first book on social systems, with Clyde and Florence Kluckhohn in anthropology, and with Freed Bales working on the first research on coding group interaction processes. After completing his Ph.D., Lyman participated with Lindemann in setting up the first community mental health center, took time out for neurology training in London, and finally began psychiatric residency at the Massachusetts General Hospital with Lindemann and Stanley Cobb. During the 1952 call-up of doctors for the Korean War, he was sent by the Public Health Service to take part in beginning the new research program at National Institute of Mental Health (NIMH) in Bethesda, Maryland.

The early years at NIMH were free-wheeling and creative. Lyman earned further psychiatric residency credit at St. Elizabeth's Hospital and completed

full psychoanalytic training as well. He experimented with innovative deviations from psychoanalysis, especially interviewing and “treating” families with schizophrenic members, with Murray Bowen doing the same across the hall. During the 1950s and 1960s, the NIMH program brought, courtesy of the doctors’ draft, such psychiatric stars as David Reiss, Will Carpenter, John Strauss, Bill Pollin, Stuart Hauser, Roger Shapiro, together with many interested visitors and colleagues, most notably Helm Stierlin, Margaret Singer, and Pekka Tienari. In the early 1960s, Lyman took a sabbatical to conduct an anthropologic study of extended families in the Bekaa Valley of Lebanon. He also began a long participation in World Health Organization research on schizophrenia. However, managing the increasingly bureaucratic NIMH programs became onerous, and Lyman left to become Chair of Psychiatry at the University of Rochester in 1971 where he initiated the Division of Programs as an environment to house interdisciplinary training, clinical services, and research; the Division flourishes to this day. After two 3-year terms as Chair, Lyman stepped down to focus more fully on family therapy and family research, especially the Rochester High-Risk Longitudinal Family Study and the Finnish Adoptive Family Study of Schizophrenia with Tienari. Clinically, he was active as a family psychiatrist, frequently seeing challenging cases with his favorite co-therapist, his wife, Adele.

In 1997, Lyman and Adele gave an endowment to the University of Rochester to start the Wynne Center for Family Research. The mission of the Wynne Center is to support family research and train new family researchers. Its first Director is Susan H. McDaniel.

In 1998, Lyman retired to Emeritus status to spend more time with Adele, their five children, and five grandchildren. He has continued to publish the results of the Finnish Adoption Study with Pekka Tienari and Karl-Erik Wahlberg. These studies document the interplay between family environment and genetics in the development of schizophrenia spectrum disorders.

Susan McDaniel

ISPS^{AND}
ITS SYMPOSIA

FIFTY YEARS OF HUMANISTIC TREATMENT OF PSYCHOSES

In Honour of the History of the International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses, 1956 - 2006.

Concluding WORDS

CONCLUDING WORDS

Manuel González de Chávez, Ann Louise Silver, Yrjö O. Alanen

This book contains a beautiful history account of the history of the science and of the beginnings of psychotherapy dedicated to schizophrenia. It discusses the pioneers who believed in it and who wanted to carry it out, develop it and make it known. It contains the history of the ISPS, now a half century old, beginning with small symposia in which experiences were exchanged, of the therapists' hopes, desires and concerns to help their patients in a closer, cordial, more effective and more human way.

Step by step, Symposium by Symposium, decade by decade, page by page, in this book we cover these fifty years of history of psychotherapy and schizophrenia as well as that of some professionals who demonstrated confidence in humans and in their capacity to cope with and recover from their most unfortunate crises.

Few times in the history of humanity, and not only in recent history, has madness had such a kind, careful and respectful approach as that received by the persons referred to in this book. A history of affection, attention and listening, of help, interests, dedication and hope, constructed piece by piece, full of humane motivations, careful observations, rigorous studies, constant reflections and especially of actions and continued relationships with, by and for the persons who suffer psychotic disorders and those with whom they live and who love them.

This trajectory was not easy nor did it produce rapid innovation of our therapeutic practices. In the same decades, biological treatments, presently obsolete ones, such as insulin coma, electroshock and even the most brutal of them, psychosurgery, widely crossed all the frontiers and were incorporated into most of the institutions. That which occurs in other sciences of human relationships also occurs in our field. The simplest, most superficial and most distant practices and theories, those which require less movement towards and dedication to others, those that treat persons as objects, extend socially and professionally faster.

It is true that our first Symposia on Psychotherapy of Schizophrenia began, as psychoanalysis itself, as closed forums only for those with invitation and known experience, that was not open to others, and that were made known through the books that included the interventions of the participants. The young Yrjö Alanen, e.g., who wanted to attend them at that time, could not do so. The organizers of the Scandinavian Symposia in the 1970s broke with this initial elitism and opened the doors of these meetings to all the professionals interested, aware that the innovation of the treatment of schizophrenic patients was a task for many professionals and should benefit many patients.

Even so, these were difficult decades for psychotherapy of schizophrenia. Purely formal and biological concepts were established, while there was greater use of neuroleptics and abundant simplistic expectations of obtaining adequate ways to eliminate each symptom with drugs. Only the most enlightened professionals were aware of the limits of biologicism and knew how to see the persons and their lives together with psychotic experiences.

Biological psychiatry in its reductionistic forms has been associated with academic and institutional power since more than one century ago. This also should not be surprising, since in our societies, political, economic and social power widely favored and used biologic ideologies to explain and justify the dominant social relationships. Thus, the wall of silence surrounding us should also not be surprising.

In fact, in most countries psychotherapies of schizophrenia and even the most integrating and global dynamic concepts of these disorders have been surrounded by a wall of silence supported by the academic and institutional power for decades. All the usual instruments, going from publications to research funds, have been used abusively to intensify and stress biological trifling matters within quantitative methodologies, but qualitatively irrelevant, not at all elucidating and quite blindly.

In benefit of our patients, breaking this wall of silence should be one of our main objectives in the coming years. They suffer this superficial and distant practice, purely pharmacological, with pain and severe consequences. It does not try to understand them and does not even propose listening to them, because they are those who suffer the silence in the first place.

As psychotherapists dedicated to these disorders, our organization and our objectives have been, up to now, greatly lagging behind our knowledge and the demonstrated benefits of our practice. These were years in which the chairmen of the successive symposia formed the only link between us, while the need for communications and exchange of experiences grew unendingly. Our formal association is very young. It is an incipient organization, that we need to reinforce and strengthen in the near future, because it is the main international reference for many thousands of therapists, and thus for severe dozen millions of persons living with these problems worldwide.

The ISPS is a privileged place of intersection and meeting between professionals dedicated to this field, who come to it with different training, orientation or degrees. They may come from schools with different perspectives and they have enriched us with their knowledge and practical experiences. It also includes the complete range of the modalities of psychotherapeutic and psychosocial help that our patients may receive.

Our association can provide us with knowledge and know-how, the most advanced knowledge and mutual understandings, always within an innovating and open mentality, seeking common factors and language, achieving a wider and global view of these disorders and developing more effective and complete therapeutic programs.

The ISPS should play a key role in teaching and training of psychotherapeutic interventions and in the spreading and generalization of the integrated programs in all the countries. This is our task: create, demonstrate, spread and organize the best possibilities of psychotherapeutic help for those suffering these problems.

Organizational and economic growth of the local societies within a large international society is the great challenge of the ISPS in the oncoming years. To achieve it, we should find the adequate balance, reinforcing a greater international society and stimulating the birth and growth of many more or less small local societies.

Establishment and development of the local societies are important for affiliation, motivation and direct knowledge of the members. Their frequent meetings in close geographic settings may be accessible to

many and stimulating and enriching for all. Furthermore, acquiring specific skills and knowledge by many professionals may be easy and continuous. This is also true for the closer and more fluid cooperation with those in power of the health care and social services and with the user and family associations.

A solid organization of the international ISPS is essential to favor the cohesion of all the members within this great richness of our extensive and valuable diversity. This organizational nucleus allows us to join our forces and initiatives, achieve the most adequate scientific, professional and social setting, profit by our resources to the maximum, make our activities a priority, offer the same will to perform and a common image to the others and give perspective of the future to our task. Definitively, we should comply with our mission and objectives in all the countries of the world.

The international organization should implement the electronic forms of information and communication between all the local societies and members of any place, organize meetings and international congresses, potentiate exchange of experiences between different countries, obtain funds to create stable networks of multidisciplinary research in our field and design highly qualified programs of education and teaching.

Publishing our own works should also be one of the main activities and priorities of ISPS in the coming years. Thanks to the books that include the main interventions of the Psychotherapy Symposiums and the fortunate live and vivid memory of their main leading figures, in this book we have been able to reconstruct our half century of history. Thanks to these books, we have gotten to know, meet and re-meet each other. We have learned and taught. We have discovered many aspects, keys and styles, interventions, techniques and strategies, much experience and much generosity.

Furthermore, book by book and Symposium by Symposium, we have been acquiring the fundamental values of the psychotherapeutic practice with psychotic patients who make up the identity signs of ISPS. On the contrary to other societies, more or less close, the ISPS members have a larger humanistic interest, a more open-listening attitude, more horizontal communication and greater desire to share and learn from the therapeutic experiences of others.

In the next decades, ISPS should develop more and faster. We no longer have to wait three years for the books of our congresses. We have initiated a Collection of books of the ISPS that should prosper with as many valuable books as we can publish. We should offer the precise theoretical and practical instruments to the mental health professionals who work in this field for their training, extension and generalization of psychotherapies in psychotic disorders.

The international ISPS should acquire organizational and economic force to allow us to decide, based on our own criterion and with greater independence, which books we want to publish. This should occur without being strictly subjected to sales estimation or survey filters or to the biased commercial conditions imposed by publishing companies. We should be our principal clients of a good part of the editions of our books. Thus, we could finance them to offer them to our associates under favorable conditions.

Being a member of ISPS and paying the annual fees should not only be the decision made to contribute to the performance of altruistic objectives, in accordance with our desires and professional practice. It should also have some more benefits. Obtaining our books at a lower price may be one of them, the same way as we register for our Congresses and Meetings at lower fees.

Our publications will be the authentic networks that extend and join us, as were, in the first decades of our history, the books of the Symposiums of Psychotherapy of Schizophrenia. Now, decades later, we have new computer instruments that facilitate direct and almost immediate contact, with fluid exchange online of all types of information and experiences. The ISPS e-mail lists make up an important contribution for our associates. Web and newsletters also contribute both to our mutual knowledge and to making us known in other settings and to other interested professionals.

After a half century of history, we now need a periodical scientific publication, an international scientific journal, that could be perfectly the ISPS Journal, with several annual issues, in which we mainly publish papers and articles on non-biological and more dynamic aspects of psychotic patients and on psychotherapeutic treatments and psychosocial interventions.

This ISPS Journal is presently a growing need. This is because there are only two international journals in the field of schizophrenia. These are very traditional in their points of view, very classically clinical and very biologicists. We could even say that they are often belligerently biologicists.

At present, the papers and articles published on psychological treatment in schizophrenia and other psychoses, including the many ones written by ISPS members, are enormously dispersed in probably more than twenty journals of all types, having varied circulation and impact, and in different languages. The articles that interest us now must be published or sought in very different journals, of different schools, modalities and interventions, from psychoanalysis to family therapies, those dedicated to rehabilitation or to those of group psychotherapy.

In ISPS, we lack a publication that groups our field and provides as a routine general and updated view of it. It would be an important step ahead to be able to launch this scientific journal and be able to consolidate it with regularity and quality. This would accelerate our growth and increase our level, cohesion and internal coherence. It is the platform that we are needing to have an influential and rapid incidence in the renovation of the perspectives and practices in this mental health field. Thus, it should be one of the future objectives of ISPS.

The future of the ISPS, after these first fifty years, will depend on us. Our economy and development as an organization, with its meetings, congresses and publications, our research and teaching activities, our influence and extension of our practices and experiences in benefit of a more human, complete and effective help to persons with psychotic problems will depend on us.

The ISPS groups persons and professionals with characteristics, activities, interests, tasks, motivations, values and knowledge that we are very proud of, as we have seen throughout all the pages of this book with emotion, admiration and gratefulness. It is exactly these common characteristics, those that make it necessary for us to have our own internal and international organization, which would be always a comfortable space for our meeting and also a reflection of us.

An organization that should be increasingly democratic, because we give preference to our international society and our local societies to those who are at the head of them at each time and because on this 50th Anniversary, we wish the ISPS to survive all of us, meeting its foundational objectives, that it grows, evolves and advances continually, is renewed over the generations and has a long historic life.

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FIFTY YEARS OF HUMANISTIC TREATMENT OF PSYCHOSES

In Honour of the History of the International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses, 1956 - 2006.

Next book! 

Next book!

“PAST, PRESENT AND FUTURE OF PSYCHOTHERAPEUTIC APPROACHES TO SCHIZOPHRENIC PSYCHOSES”

**Yrjö O. Alanen, Ann-Louise Silver, and Manuel González de Chávez
(Editors)**

This idea for this book came into being during the editorial work for the book “ISPS and the ISPS Symposia,” published in connection with the 15th ISPS conference in Madrid in June 2006 by the same editorial group, in honour of the fiftieth anniversary of the ISPS symposia.

The history of psychotherapeutic treatment of psychoses now covers about one hundred years. Still, the understanding and treatment of persons with schizophrenic psychoses on a psychological basis has remained in a minor position compared with biologically based treatment methods. In many countries, this has led to a strict dominance of one-sided viewpoints of the character of these psychoses as well as of the management and treatment of patients fallen ill with them. Patients are encountered as objects, without going more deeply in their problems. Still, the psychotherapeutic treatment methods have continually developed and their versatility increased.

In this book, the beginning of psychotherapeutic approach to schizophrenic psychoses is first described. The second part deals with the development of psychotherapeutic activities in different countries around the world, and in the third part, the present state and views for future of different treatment methods and interventions is examined, followed by an integrating chapter written by the editorial group.

We are most thankful for the distinguished psychiatrists and other authors who have participated in the writing of different chapters of the book. We hope that our book, with its comprehensive horizon, would be able to increase more integrated and humanistic approaches to the treatment of persons fallen ill with schizophrenic psychoses.

Yrjö O. Alanen, M.D. is Professor of Psychiatry (Emeritus) in the University of Turku, Finland, a psychoanalyst and family researcher. Together with his co-workers, he developed the comprehensive, both integrated and individualized psychotherapeutic approach to schizophrenic patients described in Alanen’s major work “Schizophrenia – Its Origins and Need-Adapted Treatment” (1997), now published in six different languages. He is a Life Honorary Member of the ISPS (International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses).

Ann-Louise S. Silver, M.D. (Columbia, MD, USA) is a psychoanalyst and former staff member of the well-known Chestnut Lodge Sanitarium. She is Professor of Psychiatry, Uniformed Services University of the Health Science, Bethesda, MD, U.S.A. and chairperson of the American Academy and Dynamic Psychiatry program committee. She edited the book "Psychoanalysis and the Psychosis" (1989) and has written several papers on psychotherapy as well as on the history of the psychotherapeutic treatment of schizophrenic patients in America. She is a member of the ISPS executive committee and the President of the U.S. Chapter of the ISPS.

Manuel González de Chávez M.D. is Professor of Psychiatry, Complutense Madrid University and the Chief of the Psychiatric Service of the General University Hospital "Gregorio Marañón" in Madrid, Spain. He has organized psychotherapeutically oriented Schizophrenia Courses in Madrid, very popular both in Spain and Portugal for more than ten years. He is a member of the ISPS executive committee and the organizer of the 15th ISPS Conference in Madrid in June 2006. He also made the initiative for the book "ISPS and the ISPS Symposia" published in honour of the fiftieth anniversary of the ISPS symposia, 1956-2006, which will be published in connection of the Madrid ISPS conference and is edited by the same editorial group as this book.

PREFACE

PART I: THE PAST

Early history of the treatment of schizophrenic psychoses and beginnings of the psychotherapeutic approach

In the first part of the book, the early history of the treatment of schizophrenic psychoses is described, followed by the work of the pioneers of the psychodynamic (psychoanalytically oriented) psychotherapy of psychoses during the first decades of the 20th century.

What is schizophrenia? Is it possible to approach these patients on psychological basis? (The editorial group)

In this chapter the character of the schizophrenia group disorders is described and the problem of how to understand these patients psychologically is examined in the light of history and present developments.

On early history of management and treatment of psychotic patients (The editorial group)

Here, the early history of the psychiatric management and treatment of schizophrenic disorders is examined.

The Schreber case and Freud's two-edged influence on the psychoanalytic approach to psychoses (Yrjö O Alanen).

Even if Freud himself did not work with schizophrenic patients, his psychoanalytic approach, began at the 1890s, pioneered the history of the psychodynamic understanding of schizophrenic psychoses. Especially important was his treatise (published 1911) of the autobiography of Paul Schreber, a German judge fallen ill with paranoid schizophrenia. On the other hand, Freud's pessimistic views about schizophrenic patients' lacking ability to form a transference relationship with the therapist had a notable negative influence on the development of psychoanalytically oriented psychosis psychotherapy. In this chapter, Freud's ideas on schizophrenia are examined in the light of later development.

The Burghölzli school: Bleuler, Jung, and others (Klaus Hoffmann).

The work in the Burghölzli psychiatric hospital in Zurich, Switzerland, had an important role in the development of the psychological study on schizophrenia. The name schizophrenia derives from Eugen Bleuler's monography (1911). C. G. Jung, worked in the same hospital led by professor Bleuler. He was one of the first psychodynamically oriented schizophrenia psychotherapists. This development is described by dr. Klaus Hoffmann (Reichenau, Germany) who has even earlier published important treatises on this phase in the history of psychiatry and psychotherapy.

The pioneering work of Paul Federn (Thomas Federn).

Paul Federn, a Viennese psychoanalyst, was the most important European pioneer of schizophrenia psychotherapy. He began his work with these patients already in 1906, even if he published the major reports of his abundant experience during the 1940s, having moved to the United States. Federn's work is described by his grandson Thomas Federn, a psychiatric social worker. He also deals with some of Paul Federn's early European followers.

Adolf Meyer and other American pioneers. Beginnings of psychoanalytically oriented treatment of schizophrenia in the United States (Ann-Louise S. Silver).

During the first half of 20th century, the main centres of psychodynamic psychotherapy with schizophrenic patients developed in the U.S.A. The first important pioneer was the psychiatrist Adolf Meyer, who wrote papers on this topic already during the first decade of the century. He had plenty of followers, many of them working, like Meyer himself, in important university centres.

Harry Stack Sullivan and his influence (Ann-Louise S. Silver)

Dr. Silver also has the responsibility to describe the work of the most original American psychosis psychotherapists in the U.S.A., Harry Stack Sullivan, known of his interpersonal theory of psychiatry. Sullivan began his work with schizophrenic patients in 1920s and had, during the following decades, a large influence on American psychiatry, especially within the “Washington School of Psychiatry,” represented by many important psychotherapists, who - beginning with Frieda Fromm-Reichmann - continued his work developing the core of psychoanalytically oriented psychotherapy with schizophrenic patients.

PART II: FROM PAST TO PRESENT

Developments in different parts of the world from the 1940s to the present

In this part, the later development and present state of psychotherapeutic approaches is dealt within a geographically extensive framework. This is in harmony with the ISPS’s aspiration for local activities, on the one hand, and global influence, on the other. It is also desirable and justified because of the great variation in the development of psychotherapeutic approaches and their practise between different countries, due to both theoretical and cultural reasons. We also hope that this would have a positive influence on the interest in our book in many of the countries considered.

Northern America (Ann-Louise S. Silver; with a team of interviewees dealing with different approaches). Addendum: Interview with Joanne Greenberg

United States formed the most important centre of psychoanalytic psychotherapy with schizophrenic patients during many decades after World War II. This is true both of individual and family psychotherapy. During the last decades also cognitive-behavioural orientation gained a growing foothold. Dr. Silver will describe the pioneering therapists and their ideas and achievements, by help of interviews with representatives of different therapeutic approaches. This chapter is supplemented by dr. Silver’s interview with Joanne Greenberg, the author of the book “I Never Promised You a Rose Garden” (under the pseudonym Hannah Greene).

Great Britain (Murray Jackson; David Kennard)

In Great Britain, the psychoanalytic orientation developed by Melanie Klein found many followers. The “Kleinian school” proved to be especially fruitful in the psychoanalytic understanding of schizophrenia and other psychoses. The Kleinian orientation is described by one of its leading representatives,

Dr, Murray Jackson, who also is a Life Honorary Member of the ISPS. Another part of this chapter has been written by Dr, David Kennard, the present chairman of the ISPS-UK, dealing with the strong cognitive-analytic studies and practises in Great Britain.

German-speaking Central Europe (Klaus Hoffmann [Switzerland]; Stavros Mentzos [Germany and Austria])

Another remarkable centre of psychoanalytically oriented psychotherapy with schizophrenic patients developed in Central Europe, especially in Switzerland, influenced also by existential analytic concepts (Daseinsanalyse). Especially Gaetano Benedetti, an Italian-born psychoanalyst, had a wide influence not only in the German-speaking area but also in Italy and, e.g., in the Northern European countries. Together with Christian Müller, Benedetti also established the first ISPS symposia in Switzerland during the 1950s. This orientation and the later development of psychosis psychotherapy in the German-speaking area is described by dr. Klaus Hoffmann (cf. Chapter 4) and professor Stavros Mentzos (Frankfurt, Germany), one of the leading German psychoanalysts and author of several books.

France and the French-speaking Central Europe (Francoise Davoin and Jean-Max Gaudilliere)

French-speaking psychoanalysts also had an important part in the establishment of psychosis psychotherapy in Europe after the World War II. One of the pioneering figures was the Swiss psychoanalyst Marguerite-Ann Sechehaye whose book "La Réalisation symbolique" (1947) attracted great attention. In France, the interest in psychoanalytically oriented psychotherapy of psychoses has been lively and many-sided if often remained too insufficiently known outside the French-speaking linguistic area. Its development and current trends are described by the psychoanalysts Francoise Davoin and Jean-Max Gaudilliere (Paris), both especially interested in psychosis psychotherapy.

Italy (Marco Alessandrini and Massimo Di Giannantonio)

In Italy, the most interesting feature has been the development of social psychiatry, derived from the 1978 Law 180 (also called "Basaglia Law"), requiring the closure of old-type mental hospitals. This led to a reform of psychiatric care, with strong need to develop local open-care centred services. In many areas, innovative activities were developed in the treatment of psychotic patients, including an important role of given to psychotherapy. These experiences and other psychotherapeutic trends in Italy are described by dr. Alessandrini and professor Di Giannantonio (University of Chieti).

Northern Europe (Jukka Aaltonen, Yrjö O. Alanen, Johan Cullberg, Svein Haugsgjerd, Sonja Levander, and Bent Rosenbaum). Addendum (Barbro Sandin)

Northern European countries have a long tradition of psychotherapeutic approach to schizophrenia. This is also reflected in the history of the ISPS: four of the international symposia on psychotherapy of schizophrenia have been arranged here. Besides the individual therapy, the leading features now include the development of family therapy and psychotherapeutic approaches in the field of community psychiatry, as well as a comprehensiveness of the psychotherapeutic orientation (e.g., the need-adapted approach; state-wide schizophrenia projects). The principles and results of the Northern European activities are described shortly separately in different countries by Jukka Aaltonen and Yrjö O. Alanen (Finland), Johan Cullberg and Sonja Levander (Sweden), Svein Haugsgjerd (Norway) and Bent Rosenbaum (Denmark), with a common summary. This chapter also includes a lively appendix written by Barbro Sandin, Ph.D., a Honorary Life Member of the ISPS, of her work with schizophrenic patients - which also illustrates the other side of the coin: the resistance with which psychosis psychotherapists often have to struggle in their working context.

Eastern Europe (Jacek Bomba)

This chapter includes a description of the psychotherapeutically oriented work with psychotic patients performed in the often difficult circumstances in Eastern Europe. This work, usually centred in family- and group therapeutic approaches, is described by professor Jacek Bomba (Krakow, Poland)

South-America (Jorge García Badaracco and Hernán D. Simond)

This and two following chapters are illustrating the editors' striving for a global dimension. In South-America, the psychotherapeutic approach has already a long tradition, based on psychoanalytic viewpoints and including also a strong interest in group psychotherapy. The writers, Drs. Garcia Badaracco and Simond, are psychoanalysts working in Buenos Aires, Argentine.

Eastern Asia (Lyn Chua; Dongshick Rhee)

Dr. Lyn Chua, Ph.D. (Singapore) is a member of the ISPS executive committee. She is shortly dealing with the past and present of psychotherapeutic activities including the influence of cultural background in different Eastern Asian Countries (China, Japan, Korea, Hong Kong, Indonesia, Malaysia) focusing then on her home country, Singapore. Her contribution includes a culturally-relevant form of psychotherapy developed for EPIP (Early Psychosis Intervention Programme) patients in a very

interesting way, illustrated with a case report. Professor Dongschick Rhee, a distinguished representative of the uniquely Korean brand of Taopsychotherapy, describes this treatment specifically as used in the treatment of psychotic and other seriously disordered patients.

Australia and New Zealand (John Gleeson; Jim Geekie, Dale Rook and John Read)

Dr. John Gleeson (Melbourne) is describing the development in Australia, known especially of pioneering projects in the area of prevention and early intervention in schizophrenia. Dr. Jim Geekie with his co-writers (Auckland, New Zealand) has written a highly interesting description of the development of psychotherapeutic activities with the treatment of psychotic patients, centred in early intervention services. Even here, the basic therapeutic ideas include a specific attention to the cultural background of different patients in this multi-cultural country.

Experiences of psychotherapeutic treatment in manic-depressive psychosis (Brian Koehler)

Even if psychotherapy of schizophrenic psychoses is the main topic of our book, we also found it relevant to include a chapter describing the experiences of psychotherapeutic treatment in manic-depressive psychosis. Dr. Brian Koehler (New York, N.Y., USA), is an American psychoanalyst very well acquainted with this topic.

PART III: FROM PAST AND PRESENT TO FUTURE

Different modalities of treatments and interventions: Their present state and views for future

Part III deals with the development and present state of different psychotherapeutic modalities and interventions in the treatment of schizophrenic patients. Compared with the Part II, we hope that the main focus in this part of the book will be on the present and future. Besides the traditional therapeutic modes, important attention is given to newer therapeutic methods and interventions, such as cognitive therapies, prevention and early intervention, development of community psychiatry, psychotherapeutic aspects in rehabilitation, the Soteria model and the influence of deinstitutionalization movements,

Pharmacological treatments: Their basis and limits (Jarmo Hietala, Viljo Rökköläinen and Jukka Aaltonen)

In this chapter the theoretical basis of pharmacological treatment is at first examined, the focus then transferring on clinical indications and restrictions

of neuroleptic treatment, as well as the questions dealing with the combination of psychotherapeutic activities and pharmacological treatment with each other, The authors are from Finland and have, e.g., studied together PET (positrone emission tomography) findings in new schizophrenic patients not received neuroleptic drugs. Professor Jarmo Hietala is a biologically oriented psychiatrist known of his PET findings in schizophrenia, professors Rökköläinen and Aaltonen psychoanalysts and among of the developers of the comprehensive psychotherapeutically oriented "need-adapted" treatment mode. They have also studied which kind of patients can be best be treated without any neuroleptics at all in the context of this orientation, and which kind of patients for their part get benefit of the addition of neuroleptics in small or moderate doses in the treatment schedule.

Individual psychoanalytically oriented psychotherapy (Ann-Louise S. Silver)

Dr. Silver is here examining the development of psychoanalytically oriented individual psychotherapy with special focus on its present state and orientations, indications and context.

21) The family in schizophrenic disorders: Systemic approaches (Helm Stierlin)

Professor Helm Stierlin (Heidelberg, Germany) is one of the leading pioneers in the field of family studies and family therapy with schizophrenic patients. He began his work already during 1950s, first in Germany and, then in the U.S.A., in the Chestnut Lodge sanitarium and the National Institute of Mental Health near Washington, moved back to his home country in the beginning of the 1970s and led the well-known centre for psychoanalytic basic studies and family therapy connected with the University of Heidelberg. His systemically oriented family dynamic concepts, presented in many books, have had a far-reaching influence especially in European countries. In this chapter, professor Stierlin gives an excellent summary of the development of his views and the present state of family studies and family therapy of schizophrenic patients, with a view of their further developmental needs. Helm Stierlin is a Life Honorary Member of the ISPS.

Group psychotherapy and schizophrenia (Manuel González de Chávez)

Group psychotherapy and other group activities with schizophrenic patients is one of the special interests of Dr. Manuel González de Chávez. He describes the development and present state of these activities, their main principles, important role, context, goals and results, and discusses future views of the group approach in the treatment of schizophrenic patients.

Cognitive and behavioural therapies (Douglas Turkington and Rob Dudley)

Doctors Turkington (Nottingham, U.K.) and Rob Dudley (Newcastle, U.K.) describe the leading methods, principles, goals and results of cognitive and behavioural therapies in the psychotherapeutic approach to schizophrenia. These principles have been applied both in the treatment of individual patients, families and the activities of therapeutic communities.

Prevention and early intervention (Patrick D McGorry)

Preventive activities and different forms of early intervention have proved to have an important key position in the treatment of schizophrenic psychoses already because of the positive effect of early treatment to the outcome of schizophrenia, indicated by several studies. Professor McGorry from Melbourne, Australia, is one of the most important pioneers of these activities. He has led pioneering projects on psychological treatment of early psychosis and has written and edited several books dealing with these topics.

Psychotherapy and rehabilitation (Courtenay Harding)

Professor Harding, now in Denver, Colorado, U.S.A. led the long-time follow-up of an extensive rehabilitation programme carried out in the state of Vermont during 1950es and 1960, with a matched control group. It was found that the outcome of the rehabilitation group was better, even exceptionally good compared with the usual outcome figures reported in schizophrenia literature. Dr. Harding has written widely of the effects of social factors and psychotherapeutically oriented understanding of schizophrenic patients on their life and on the outcome of their disorder.

Community psychiatry, therapeutic communities and therapeutic setting experiences (Johan Cullberg)

Professor Cullberg, a psychoanalyst and social psychiatrist from Stockholm, Sweden, is one of the important pioneers of psychotherapeutic practises in the field of community psychiatry, known of many books written on psychodynamic psychiatry and psychoses (esp. Psychosis, Humanistic and Biological Approach). He is the former chairman of the ISPS and a Life Honorary Member of this association. Cullberg has now led an extensive (17 centres, with a distinguished university department as the control) project (Parachute project) dealing with the development and results of the comprehensive psychotherapeutic orientation in the treatment of new patients from the schizophrenia group, so continuing the Northern European studies in this area. One of the special features of this project is also the use

of small treatment homes in many of the centres. On the ground of his wide experiences, Cullberg will here examine the developing of community psychiatric activities with schizophrenic patients on a comprehensive psychotherapeutically oriented basis, including the results of the Parachute project.

The Soteria model (Volkmar Aderhold)

Dr Aderhold, a psychiatrist from Hamburg, Germany, is specifically acquainted with the activities of the Soteria model, established by the U.S. psychiatrist Loren S. Moshier during the 1970s. The heart of the model are the Soteria homes, small homes outside the hospitals functioning as centres for a humanistic, psychotherapeutically oriented encounter of acute psychotic patients, originally with specially selected lay staff, in professional control. This treatment model has spread also in Europe (usually with professional staff members), one of the most well-known representatives being the "Soteria Berne", established by professor Luc Ciompi. Dr. Aderhold is describing the basic ideas, principles and activities of the Soteria homes as well as follow-up studies of the patients .

The influence of deinstitutionalization movements (Robert Whitaker)

Mr. Whitaker is the author of the well-known book "Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally", with hard critic of the contemporary psychiatric treatment of psychotic patients. In this chapter, Bob Whitaker is especially examining the shady side of neuroleptic treatment, with its hidden violence and adverse side-effects, also showing that the long-term results of the drug treatment seem to be rather poor.

PART IV: ON FUTURE

Developing psychotherapeutic approaches today

29) Further development of our treatment approaches to schizophrenia: an integrated view (The editorial group)

In this chapter the editorial group will present summarizing notions about the developmental needs of the treatment of schizophrenic psychoses, based on the views by the authors of different chapters as well as the experiences of the members of the editorial group members themselves.

The relevant topics include:

- The heterogenic nature of schizophrenia: Implications for therapy
- The position of individual psychotherapy
- The position of family- and environment- centred activities
- The key position of prevention and early intervention
- On drug treatment and combining of drugs with psychological treatment modes
- Health service organizations and psychotherapy. The quality and dimensions of psychiatric care
- Obstacles to the development of psychotherapy with schizophrenic patients
- The question of evidence
- The crucial importance of an integrated approach

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